

Writing Good Care Plans

A good practice guide



Core Care Standard Care Planning
You will have a clear care plan



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1 Introduction

Purpose

This booklet is intended to support good practice in Care Planning, through a summary of current policy, standards, guidance and recommendations, together with tips and suggestions about how to write a good care plan which:

- Meets professional, local and national standards;
- Clearly outlines aims, actions and responsibilities;
- Supports care planning under systems such as: the Care Programme Approach, Health Action Planning etc.
- Interacts effectively with other care planning systems; and
- Is accessible to everyone who is part of it.

Care Plan

A plan of care is something that describes in an easy accessible way the services and support being provided, and should be put together and agreed with the person through the process of care planning and review.

Care Planning involves:

- **Gathering and sharing stories:** the views of all concerned, including the persons/child's, family/carers, and professionals views
- A **systematic review** of the areas of need
- **Exploring and discussing information:** to help work out what's most important
- **Goal setting:** what do we want to achieve?
- **Action planning:** what are we going to do, who is responsible, and when will it be reviewed?
- **Risk Management:** how do we make care as safe as possible?

A Care plan is:

- A record of needs, actions, and responsibilities;
- A tool for managing risk;
- A plan which can be used and understood by service users/patients, families and carers and other agencies, as well as colleagues, in a crisis;
- Something which people feel they own;
- Based on a thorough assessment of need;
- A multi-professional, multi-agency endeavour;
- Co-ordinated by the most appropriate person, such as a Care Co-ordinator;
- Produced in the most appropriate forum;
- Shared effectively with those who are part of it;
- the written record of a plan of action negotiated with the person to meet their health and social needs



A Care Plan is not:

- a bureaucratic exercise, but is an essential element in engaging service users and communicating what the service can and will do, and what responsibilities they, family and carers, and the person concerned, will have; or
- a wish list, but is a plan of agreed elements of care
- a waste of time, but a valuable aid to providing care that everyone understands and has agreed to



See www.corecarestandards.co.uk for more information about the standard

2 Standards

Standards for care planning come from a number of sources,

1. The Trust Core Care Standard for Care Planning is:

You will have a clear care plan

2. The Care Quality Commission 'Essential Standards of Quality and Safety', includes Outcome 4 The Care and Welfare of people who use services. This requires that :

The assessment, planning and delivery of their care, treatment and support:

- **Is centred on them as an individual and considers all aspects of their individual circumstances, and their immediate and longer-term needs.**
- **Is developed with them, and/or those acting on their behalf.**
- **Reflects their needs, preferences and diversity.**
- **Identifies risks, and says how these will be managed and reviewed.**

Ensure that plans of care, treatment and support are implemented, flexible, regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service.

See References for specific provisions

3. Legislation and policy including
 - a. **The NHS and Community Care Act 1990**
 - b. **The Children Act 1989**
 - c. **The Mental Health Act 1983**
 - d. **The Mental Capacity Act 2004**
 - e. **Various Carers Acts**



3 Where and how the care plan should be written

This may have a major impact on how effective the care plan is. A care plan that is written by one person alone in an office may include all the key elements, but is not likely to be as effective in practice as one which is written in partnership with the person and those who are contributing to the plan.



A sense of ownership by all those concerned (and in particular the person themselves) is vital in making the plan translate into reality, which can be promoted by:

- **Using people's own words and phrases** (familiar and comfortable language, which avoids jargon and abbreviations);
- Recognising that **care plans exist for the benefit of the service user**, and should be based around the needs of that person, not around the services available;
- **Involving the person in agreeing and writing** the care plan as much as possible, including the opportunity to sign the care plan;
- Producing the plan in a **format and style that the person is comfortable with**
- **Being flexible** in the approach to the service users involvement;

Often, concerns are expressed about the time needed to write comprehensive plans and, as a result, care plans can become jargonised shorthand for what services will do. This type of plan is unhelpful to service users, carers and staff.

- **Set realistic time aside for this important Care Standard**

3 Content of care plans

Care plans for all service users should include:



- **Why** are we doing this? (aims)
- **What** are we planning to achieve? (outcomes)
- **How** are we going to do it? (actions)
- **Who** will do it? (responsibilities)
- **Where** will it be done? (times, locations)
- **When** will it be done by? (timescales)
- Any needs relating to **REGARDS** (race and culture, economic disadvantage, gender, age, religion/spirituality, disability or sexuality)

The care plan should also:

- ✓ Include the persons role
- ✓ Focus on peoples strengths
- ✓ Reflect the individuals cultural and ethnic background as well as their gender and sexuality
- ✓ Include action and outcomes in all relevant aspects of an individual's life
- ✓ Include crisis and contingency arrangements;
- ✓ Give the date of the next planned review (within a year).
- ✓ Reflect transfer details if appropriate
- ✓ Identify unmet needs

4 Crisis and contingency plans

Crisis and contingency plans must be based on the individual circumstances of the person, however, where there are no risks identified, a **contact card** may be sufficient. This must include 24 hour/7 day a week contact details.



- **Crisis plans** should set out the action to be taken if the service user becomes very ill, or their health is deteriorating rapidly. The plan must include:
 - Who the **service user responds best to** and how to contact them;
 - **Previous strategies** that have been successful in similar situations;
 - **Early warning signs** and relapse indicators;
- **Contingency plans** should help to prevent a crisis developing when, at short notice, the Co-ordinator is not available or part of the care plan cannot be provided. The plan must include:
 - Information about **who to contact** if the Co-ordinator is not available;
 - A **contingency** for any key elements of the care plan.

Good practice example:

When Jay stops making eye contact and starts pacing, make sure that he has a quiet place to go where other people will not disturb him, contact his Mum, and his GP.

In practice it may be useful to think about:



- Which elements of the care plan are essential
- Those elements without which the person's well-being or safety would be seriously compromised
- Making sure that you have the understanding and acceptance of their role, of those mentioned in the plan
- Crisis plans for people with more complex needs, such as those who need CPA, should be more than just a list of telephone numbers
- Crisis plans will often be referred to when the service user is experiencing distress, and events may be fast-moving
- They should reflect service users views and wishes
- It should be written with the service user and their carer(s) wherever possible
- By being explicit and instructional the plan is more beneficial to both the service user, their carer(s) and other service staff

5 Carer's Support Plan

All informal carers who provide regular and substantial support for a service user are entitled to an assessment of their caring, physical and mental health needs, and a support plan to meet those needs.



This may include (depending on the needs identified):

- **Information**, including where and how to access services, both during office hours and in a crisis;
- Action to meet defined **contingencies**;
- What will be provided to meet the carers identified **mental and physical health** needs;
- Action needed to secure **advice** on income, housing, educational and employment matters;
- Arrangements for short term breaks/**respite**;
- Arrangements for **social support**, including access to carers support groups;
- Information about appeals or **complaints procedures**.

The plan may (with everyone's agreement) be part of a joint one with the service user.

Where no needs are identified, or the carer refuses an assessment, a contact card for the carer may meet the requirements of the support plan (which should include who to contact out of hours).

The support plan must be reviewed at least annually.

Other agencies may be commissioned to provide the assessment and support plan. For more information see the Core Care Standards website www.corecarestandards.co.uk

Write a support plan for a carer who needs support with a leisure activity:

6 Writing Good Care Plans

Think logically and objectively about what is being written.

We often use statements such as 'monitor' mental health' or 'monitor medication' with no indication about what precise aspects of someone's mental health should be monitored, or how these should be monitored



Remember:

- Service users can write their own care plans if they so wish
- Service users receive a copy of their care plan and have an opportunity to sign to say that they agree with the plan.
- If service users don't want to be involved, make a note of this, and ask them again later
- Care plans reflect the needs of the individual

In practice, it may be useful to write...

- the care plan as 'I need', to encourage the service user to think about what he/she needs
- Statements of action that are instructional and able to be followed in your absence.
- Interventions that relate directly to the needs and goals

To make text more inviting to read, use:

- ✓ **Short sentences** – in general no more than 15-20 words long
- ✓ **Present and active tenses**, where possible, for example, 'your appointment is on...' not 'your appointment has been made for...'

- ✓ **Bulleted or numbered points** to divide up complicated information
- ✓ **Small blocks of text.** Do not use long paragraphs – divide them up using headings and new paragraphs
- ✓ **White space** makes the information easier to read
- ✓ **Large bold font emphasizes text.** Avoid UPPER CASE letters, *italics*, and underlining as they make the text more difficult to read. **WRITING IN CAPITALS READS AS IF YOU'RE SHOUTING.**
- ✓ **Numbers** from one to nine are easier to read if they are in words, and numbers from 10 can be represented as numbers
- ✓ The **font size** should be between 12 point (minimum) and 14 point. However, if you are providing information for elderly people, or those with sight difficulties, you should always use at least 14 point.
- ✓ **Typed information** should usually be in Ariel font

Identifying needs:

Care plans should always identify needs (rather than services) i.e. Instead of: *Need = Home help*

It should read: *Need = Have a fire lit and help with morning routines*

Accuracy and completeness:

The care plan should always be able to be picked up and used by colleagues if the Care Co-ordinator or lead professional is not there, so must include enough information for someone else to implement the plan i.e. rather than:

Need	Action	Responsible
Home help	every day	DSO

The Action to meet the need might be to have a home help, or support for the person to learn to do this, or to consider a change

of heat source, depending on what the person feels would best support their independence.

Good practice example:

Need

Support to enable John to live independently

Action

1. Support worker to visit John each day at agreed times and places for 1 hour Monday – Friday to:
 - Remind him of appointments and medication
 - Provide a chance for John to develop skills in self-care by working with him on things like fire-lighting
2. Support worker to attend reviews with John
3. Review in 3 months time

Responsible

Stella Jones (Support worker Recovery team 3)

John Smith (service user)

Try writing a better care plan Instead of:

Need

Day Hospital

Action

Reminiscence Every Thursday

Responsible

Manager

A better care plan would be:

Need

Action

Responsible

Service User-Centred plans

It can be very effective to write care plans in a service user-centred way, as if in the persons own voice. The example below shows the difference in approach

Intervention

Monitor side-effects of medication

Service user-centred intervention

1. I will tell my Gill my Care Co-ordinator if I have any side-effects from the medication, such as vomiting, shaking, headaches, nausea, or stiffness in my joints. When I see Gill, she will ask me about this.
2. Gill will write down any side-effects in my notes and talk to the doctor about them with me.
3. Gill and I will fill in a rating scale to help manage any side-effects

Complex Care Plans

Care Plans often include other agencies, but there are some situations in which it is particularly important to have clear information, and to explain in more detail what all the responsibilities are, particularly where the person:

- ✓ Has a learning disability
- ✓ Has substance misuse problems
- ✓ Misuses alcohol
- ✓ Has safeguarding issues
- ✓ Is a vulnerable adult
- ✓ Has cognitive problems
- ✓ Is a child

7 Accessibility and Communication

Until a care plan has been effectively communicated to the people who need to see it, it remains only a plan. A care plan found only in the file will not work very well.



However, simply sending out a written copy in English on paper may not be enough, and some of the recipients may not be able to access this. Issues to consider include:

- ? Level of **literacy** of the reader/s
- ? Use of **languages other than English**
- ? **Sensory impairments** and disabilities
- ? **Cognitive impairment**
- ? **Age**

It is also essential that the care plan is legible, and typed/printed plans are to be preferred wherever possible.

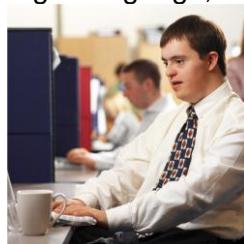
When writing information for service users, remember the following points:

- ✓ Use everyday language. Avoid jargon and acronyms, and use plain language to make it easier to read. As many as seven million people (about one in five adults) in England have problems with basic literacy and numeracy, but that does not mean that you should be patronising or use childish language (Lord Moser 'A Fresh Start' 1999)
- ✓ Use service user-friendly text. Use personal pronouns such as 'we' and 'you'. Do not use frightening language. It is difficult to avoid using some medical terminology, but give an explanation
- ✓ Avoid instructions. For example, do not just say 'don't eat anything for 12 hours before an operation – explain why

- ✓ Be up to date. Give the most recent practice and latest phone numbers
- ✓ Let people know if the information is available in other formats, for example a CD or tape

Consider the need to use:

- ✓ Manual/sign languages such as British Sign Language, Makaton, Braille etc.
- ✓ Simplified language
- ✓ Larger size type
- ✓ Symbols or pictures
- ✓ Audio tapes, Video tapes/DVD's
- ✓ Translation into languages other than English



So the care plan must be sent to everyone who plays a part in it, and made available to people who do not regularly play a part in it but may need access in a crisis, by making sure it is held in an accessible IT system, as well as in files.

8 Responsibilities of the Co-ordinator

The Co-ordinator is responsible for making sure that the care plan is:

- Produced;
- Includes a crisis and contingency plan;
- Co-ordinated;
- Circulated;
- Reviewed



However, someone else may carry out these functions, as long as the Co-ordinator co-ordinates them.

In practice it would be useful to ask:

- ? What the service user would like from mental health services
- ? What he/she would like to achieve
- ? How they feel this could be achieved
- ? How they feel they could contribute
- ? About who the service user feels comfortable for you to talk with, and gain permission for this

In practice it would be useful to think about:

- the care plan being read by someone other than yourself
- actions being SMART (specific, realistic and achievable (with resources available))
- the care plan being a useful communication tool in times of relapse or crisis
- what level of detail is needed in the plan to achieve the goals
- what support is needed and in what circumstances

Imagine:

- If you were not at work would another worker be able to identify what to do?
- Trying to work out if there is a plan for what to do in an emergency if it's not in the care plan?
- Trying to follow another worker's care plan that is too broad to be of use to the service user and other staff

9 Different types of care plan

There are a number of different planning processes that may impact on people using health services. The guidance provided in this booklet is appropriate for the majority of these. Where different or expanded standards apply, these have been listed. A brief summary of the main types is provided below:



Mental Health Care Plan (if CPA is not needed)

- A plan produced as the result of a mental health assessment of need
- A written plan which may be either produced on a care plan form/format or as part of a letter which is identified as being a care plan
- Co-ordinated by a lead professional
- Reviewed at least every year

Mental Health Care Plan (CPA is needed)

- A plan produced as the result of a mental health assessment of need
- A written plan which may be either produced on a care plan form/format or as part of a letter which is identified as being a care plan
- Co-ordinated by a Care Co-ordinator
- Reviewed at least every year, with the date of the next review set at this one

Carers Support Plan

- A plan produced as the result of an assessment of a carer's mental and physical health needs, caring, leisure and employment needs

- It will always be written, but may be in the form of a contact card, a separate written plan, or as part of a joint plan with the service user
- May be co-ordinated by the (Care Co-ordinator or lead professional, but where the assessment and majority of the service is provided by mainstream social services, co-ordination may be done there, or by a service commissioned to provide the service
- Reviewed at least annually

Section 117 aftercare plan

- A plan produced for someone with an entitlement to aftercare under s.117 of the Mental Health Act 1983 (who has been on a s.3, 37, 47, 48). Services provided under the plan cannot be charged for by health or social services (e.g. residential care)
- A written plan, which must be signed on behalf of health and social services. It must be produced before the person is discharged from hospital, preferably at the s.117 pre-discharge meeting (see Mental Health Act 1983 Code of Practice for guidance).
- Co-ordinated by a (CPA) Care Co-ordinator
- Reviewed at least every year as part of the regular CPA review. Entitlement under s.117 must be signed off by both health and social services when the person no longer needs mental health aftercare, within 3 months of the discharge.

Direct Payments Plan

Direct Payments are cash payments made in lieu of some services to individuals who have been assessed as needing community care services to meet social needs. They can be made to disabled people aged over 16, parents of disabled children, or carers aged over 16.

- A plan produced to provide community care, which should include:

- Needs identified which relate to direct payments
- How the services will be secured, what support will the service user need, and how it will be provided
- Emergency cover arrangements
- Costs and any contributions
- Monitoring and review arrangements
- Conditions and arrangements for discontinuance
- A written plan, which should be copied to the service user. The plan may include some services provided directly and some through direct payments. It may be part of the overall care plan
- Co-ordinated by the Care Co-ordinator or social services worker
- Reviewed regularly

Wellness Recovery Action Plan (WRAP)

WRAP is a self-help system developed by people with personal experience of mental health problems, struggling to cope and develop a healthier lifestyle. It is a systematic approach to self-managing your life and promoting self-growth, self-esteem and developing coping strategies that work for you.

WRAP is a written plan that moves and changes with you becoming your personal plan to help you cope with life and everything it throws your way. WRAP will help you monitor your life and help you stay well and in charge of your life even when you become unwell or when life changes cause you problems you didn't foresee.

- A plan written by the person themselves and covering:
 - Daily maintenance plan (feeling well, daily list, dreams and goals reminder list)
 - Wellness tools (strategies to promote well-being)
 - Symptom monitoring
 - Triggers and early warning signs

- Crisis plan (feeling well, symptoms, supporters, health care and treatments)
- Post crisis plan (recognising recovery)

It may cover all the issues required under CPA, or a supplementary/joint care plan may be needed. This should be discussed between the service user and Care Co-ordinator

- A written plan, shared at the person's choice
- Co-ordinated by the person themselves
- Reviewed whenever the person wishes

Health Action Plan (LD)

An action plan offered to people with learning disabilities to describe the services being provided to support them. For people with mental health problems and learning disabilities, this equates with the CPA care plan

- A written plan which forms part of the person-centred plan
- Produced in partnership with the person primary care and GP's
- Reviewed at the following stages of the person's life:
 - Transition from secondary education with a process for on-going referral;
 - Leaving home to move into a residential service
 - Moving home from one provider to another
 - Moving to an out of area placement
 - Changes in health status, for example as a result of a period of in-patient treatment
 - On retirement
 - When planning transition for those living with older family carers

Long Term Conditions Care Plans

Long term conditions care plans are used for adults and children living with long term conditions such as diabetes or COPD. They are used in Primary Care, and include the stages of: Preparing, Planning, and Maintaining.

- The care plan is simply a record of the outcomes of the care planning discussion between an individual and their healthcare professional. A personalised care plan should include other information such as agreed goals, personal preferences, aspirations and goals, and contingency plans in addition to treatment plans. The plan is owned by the individual.
- The plan is co-ordinated by the health professional and the individual
- The plan is usually reviewed annually by the individual and the health staff in partnership

Looked after children Care Plans

The local authority has a primary duty set out in section 22(3) of the 1989 Children Act to safeguard and promote the welfare of the looked after child and to act as good corporate parents to enable each looked after child to achieve his/her full potential in life. Care planning and case reviews are about bringing together children who are looked after, their families, the child's carers and professionals, in order to plan for the care of the child and to review that plan on a regular basis. The child's care plan provides the overarching vehicle for bringing together information from the assessment across the seven dimensions of the child's developmental needs [regulation5] and from any other assessments of the child and his/her family. The health and education dimensions of the care plan are populated by the health plan [regulation7] and the personal education plan (PEP) [regulation5(b)(ii)].

Using the dimensions relating to a child's developmental needs, parenting capacity and wider family and environmental factors, the care plan should be based on the information ascertained

from the assessment and draw on knowledge about interventions that are likely to be most effective for the needs to be addressed..

Person Centred Plan (PCP)

A plan which starts with the wishes and aspirations of the individual with learning disabilities, and which should help the person exercise choice about housing, education, employment, support and leisure

- A written/pictorial plan
- Co-ordinated by the person themselves
- Reviewed whenever they wish

Prisoners Release plans

Where a person now in prison was previously cared for by mental health services, and they have been supported through CPA in prison, the care plan should (with the prisoner's consent) be formulated with the full involvement of their Care Co-ordinator before release. Its aim is to provide on-going integrated and effective aftercare for prisoners with mental health, substance misuse, or co-morbidity problems. To provide a flexible aftercare service which is responsive to the complex aftercare needs of high-risk ex-prisoners and to provide seamless continuity of care for ex-prisoners on CPA

- A written plan, copied to the prisoner
- Co-ordinated by the Prison Healthcare service working with the (CPA) Care Co-ordinator
- Reviewed at least every six months, including police, probation and housing colleagues where relevant.

10 References

Essential Standards of Quality and Safety

Care Quality Commission Outcome 4 - Care and Welfare of people who use services

Care and welfare of service users Regulation 9.—(1) The registered person must take proper steps to ensure that: each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of—

(a) the carrying out of an assessment of the needs of the service user;

and

(b) the planning and delivery of care and, where appropriate, treatment

in such a way as to—

(i) meet the service user's individual needs,

(ii) ensure the welfare and safety of the service user,

(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment, and

(iv) avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user's individual needs.

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Prompt: People who use services have safe and appropriate care, treatment and support because their individual needs are established from when they are referred or begin to use the service. The assessment, planning and delivery of their care, treatment and support:

- Is centred on them as an individual and considers all aspects of their individual circumstances, and their immediate and longer-term needs.
- Is developed with them, and/or those acting on their behalf.
- Reflects their needs, preferences and diversity.

- Identifies risks, and says how these will be managed and reviewed.
- Ensures that risk assessments balance safety and effectiveness with the right of the person who uses the service to make choices, taking account of their capacity to make those choices and their right to take informed risks.
- Ensures that plans of care, treatment and support are implemented, flexible, regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service.
- Maintains their welfare and promotes their wellbeing by taking account of all their needs, including:
 - physical
 - mental
 - social
 - personal relationships
 - emotional
 - daytime activity
- Ensures continuity in their care, treatment and support as a result of effective communication between all of those who provide it, including other providers.
- Enables people to maintain, return to, or manage changes to their health or social circumstances.
- Is undertaken to reduce the risk of deterioration in their health status.
- Encourages the prevention and early detection of ill health, including relapse, wherever there are real factors that present a risk to their health and welfare.
- Enables them to make healthy living choices concerning exercise, diet and lifestyle.

Children who use services are:

- Fully informed of their care, treatment and support.
- Able to take part in decision making to the fullest extent that is possible.
- Asked if they agree for their parents or guardians to be involved in decisions they need to make.

- Able to benefit from an environment that is appropriate to their age and individual needs.

People who use services have their needs met through the care programme approach:

- If they meet the criteria set out in Refocusing the Care Programme Approach: policy and positive practice guidance 2008.

People with a learning disability who use services:

- Are supported to have a health action plan developed by their primary care trust.

People using rehabilitation or treatment services for substance misuse have:

- Their care, treatment and support options explained before they start to use the service. These include any restrictions identified, and the alternatives, risks and benefits.



11 Trust Recording standards

Standard 1 - Health records (however recorded) contributing to the care of the service user to be **accessible to Health staff** involved in the care of the service user



Standard 2 - Health records (however recorded) contributing to the care of the /person **to be accessible** to them as appropriate to their circumstances

Standard 3 - Health records to contain a complete set of **identification data**

Standard 4 - Health records to be **contemporaneous, up-to-date and chronological**

Standard 5 - Health records to be **legible**

Standard 6 - All entries in Health records to be **dated, timed, and signed**

Standard 7 - Health records to be maintained in a way **that enhances accuracy**

Standard 8 - **Alerts**, including allergies and reactions to be completed within the Health record

Standard 9 - The Health record to (a) contain all relevant clinical information, **(b) be of high quality, and (c) be complete**

Standard 10 - The Health record must contain information about **children who are in regular contact** with patients/service users, clearly identifying any safeguarding concerns. The child health record must contain any safeguarding concerns.

Standard 11 - The Health record to include clear evidence of all **patient/service user and carer involvement**

Standard 12 - The Health record to contain **discharge/transfer/leave** information