Care Planning Guidance

Contents

Introduction

Effective care planning is central to delivering safe, person-centred, and high-quality care. This guidance document has been developed to provide a clear and practical framework for creating, implementing, and reviewing care plans across Kingsley HealthCare.

A care plan is more than a record of needs and interventions—it is a collaborative tool that reflects the individual's values, choices, and goals. It should support independence and wellbeing, while ensuring that risks are identified and managed appropriately.

This guidance is designed to:

- Promote consistency and best practice in care planning.
- Ensure that plans are tailored to each person's unique circumstances.
- Support staff to work in partnership with individuals, their families, and multidisciplinary teams.

By following this guidance, staff can create care plans that are not only compliant with regulatory standards but also meaningful and responsive to the people they are designed to support.

Under each section of the guidance, you will find examples of the details required within each section of the Care Plan. These examples should be used to help you gain an understanding of where to put the key details of the Care Plan, when creating this on Nourish.

Advanced Planning

Advanced planning is an essential aspect of care that ensures a person's preferences, values, and wishes are recognised and respected both now and in the future. It involves anticipating potential changes in health, wellbeing, or circumstances and making proactive arrangements to guide decisions if the individual becomes unable to express their choices.

This section provides guidance on how to record preferences clearly, and ensure that advanced care plans remain person-centred, legally valid, and regularly reviewed.

Identified Need wording examples…

- The individual wishes to receive care that reflects their values and beliefs, and to remain in their preferred place of care.
- The individual lacks capacity to make specific decisions about care and treatment.
- The individual may experience pain and symptoms as part of their deteriorating condition.
- The person expresses a need for emotional reassurance and/or spiritual guidance as they approach the end of life.
- The family wants to be involved in care planning and receive regular updates.
- The individual is at risk of pain and discomfort as they near the end of life.
- The individual has expressed a wish to remain in their current setting and not be transferred to hospital.
- The individual is no longer able to eat or drink adequately due to the natural dying process.

Identified Need additional notes…

You should also include details of whether the individual has a DNACPR or a ReSPECT form in place (and ensure that a copy is attached to the care plan).

Planned Outcome wording examples…

- Care is delivered in line with the individual's expressed wishes, including preferred place of care and avoiding unnecessary hospital admissions.
- Decisions made are in the individual's best interests, considering any prior expressed wishes.
- Pain and symptoms are effectively managed to maintain comfort and dignity.
- The individual feels emotionally and spiritually supported.
- Family members feel informed, supported, and included in decision-making.
- The individual remains as comfortable and pain-free as possible.
- The individual remains in their preferred place of care and dies peacefully in familiar surroundings.
- The individual is not caused distress through forced nutrition/hydration.

How to achieve Outcome…

- Document preferences clearly in the care plan and communicate to all relevant professionals.
- Share plan with GP, out-of-hours services, and ambulance crews.
- Review and update preferences regularly.
- Complete mental capacity assessments when appropriate.
- Record best interest decisions involving family and professionals.
- Refer to any existing Advance Statements or informal preferences.
- Involve Independent Mental Capacity Advocate (IMCA) if no family or legal representative.
- Liaise with GP and palliative care team for anticipatory medications.
- Ensure regular pain assessments and monitor non-verbal signs.
- Maintain comfort through repositioning, mouth care, and hydration as appropriate.
- Arrange access to spiritual advisors or chaplains.
- Offer regular emotional support from familiar staff.
- Facilitate personal rituals, music, or readings that bring comfort.
- Provide a calm, respectful environment for reflection and peace.
- Identify a lead family contact and agree on frequency of updates.
- Involve family in care plan reviews and best interest discussions.
- Offer emotional support and signpost to bereavement services.
- Maintain open communication channels, especially during deterioration.
- Administer prescribed pain relief and anticipatory medications promptly.
- Monitor for signs of pain, including non-verbal cues.
- Liaise with GP and palliative care team for symptom control.
- Reposition regularly using slide sheets to prevent pressure damage
- Avoid unnecessary interventions or hospital transfers.
- Coordinate care with GP, district nurses, and out-of-hours teams
- Offer sips, mouth care, and moist sponges for comfort if appropriate.
- Explain to family the normal changes during the dying phase.
- Monitor for signs of aspiration or discomfort.
- Include any funeral details i.e. which company.

Communication

Clear, respectful, and consistent communication is the foundation of effective care planning. It ensures that individuals, families, and professionals share a common understanding of needs, preferences, and agreed actions. Good communication not only supports person-centred care but also helps to build trust, reduce misunderstandings, and promote collaboration between everyone involved.

This section outlines best practice approaches for ensuring that information is recorded and shared appropriately.

Identified Need wording examples…

- The individual has hearing loss and struggles to hear staff and other residents.
- The individual has expressive aphasia and finds it difficult to form words or sentences.
- The individual uses a communication aid (e.g. picture board, electronic device) to communicate needs and preferences.
- The individual becomes anxious or distressed when they are not understood.
- The individual is non-verbal and communicates through gestures, facial expressions, or body language.
- English is not the individual's first language, and they may require support with interpretation or translation.
- The individual has cognitive impairment (e.g. dementia) which affects their ability to follow conversations.
- The individual is at risk of social isolation due to communication challenges.
- The individual is able to communicate effectively and does not have any identified communication needs.

Identified Need additional notes to consider…

- Does the individual have a hearing impairment or other ear condition?
- Does the individual have a visual impairment or other eye condition? e.g. cataracts.
- Does the individual wear glasses/contact lenses and what for? e.g. all the time or just for reading.

Planned Outcome wording examples…

- To express basic needs and preferences clearly and confidently, using their preferred method of communication (e.g. speech, gestures, communication aid).
- To understand and respond appropriately to everyday communication, such as staff instructions, greetings, or questions.
- To maintain social interaction with family, staff, and other residents to reduce isolation and promote emotional wellbeing.
- To use hearing aids, glasses, or other communication aids effectively (if applicable).
- To reduce frustration or distress associated with communication difficulties by using tailored strategies or tools.
- The individual remains socially engaged and feels included in the care home community
- The individual is able to express their care preferences clearly and participate in decision-making.
- Continues to express their needs, preferences, and emotions clearly and effectively.
- Staff continue to understand and respond appropriately to [Name]'s verbal and non-verbal communication.
- Maintain a respectful and attentive approach when communicating with [Name].
- Provide opportunities for [Name] to express their choices and opinions throughout the day.
- Continue using verbal communication as the primary method of interaction.
- Ensure a calm and quiet environment where [Name] can engage in meaningful conversation if they choose.
- Observe for any changes in [Name]'s ability to communicate and report promptly if concerns arise.

How to achieve Outcome…

- Ensure the hearing aid is worn, clean, and working properly.
- Speak clearly and face the person when talking.
- Minimise background noise where possible.
- Encourage regular hearing aid checks and maintenance.
- Allow extra time for responses; avoid rushing.
- Use short, simple sentences and check for understanding.
- Offer visual prompts or cues if needed.
- Provide reassurance and maintain a calm, respectful tone.
- Use familiar words and visual aids if available.
- Involve family or interpreters for care planning when appropriate.
- Avoid idioms or slang and repeat/rephrase if needed.
- Document key phrases or words the person understands better
- Encourage participation in group activities tailored to their communication level.
- Facilitate regular contact with family (calls, visits, video chats).
- Staff to initiate regular friendly conversation and check-ins.
- Assign key workers familiar with the person's communication needs.
- Do they use braille, large print or audio equipment?
- Does the person have regular sight tests?
- Do they need support to attend appointments?
- Does the person use a hearing aid? Which ear? When do they wash it? e.g. overnight or just during the day. Where can the batteries be obtained from and how to fit into the aids?
- Do they use subtitles on the TV?
- Do they use a loop system?
- Does the person have regular hearing tests?
- Ensure glasses are worn and clean at all times.
- Use large-print materials or pictorial aids for daily routines and choices
- Sit directly in front of the individual and maintain eye contact when speaking
- Use gestures and facial expressions to support verbal communication
- How do they summon assistance?
- Do they use the call bell, shout, bang things?
- Do they use any other means of expressing themselves such as crying, waving, shouting, smiling, singing, touching?

Creams

The safe and effective use of creams and topical preparations is an important part of many individuals' care routines. Proper application not only supports skin integrity and comfort but can also prevent infection, relieve symptoms, and promote healing.

This section provides guidance on recording details of creams applications, ensuring that treatment is delivered consistently, safely, and with respect for the individual's dignity and preferences.

Identified Need wording examples…
• The individual requires prescribed creams/topical treatments to maintain skin integrity and manage skin conditions (e.g., dryness, eczema, pressure areas, or fungal infections). – please see details on Camascope. • The individual has dry, fragile, or sensitive skin and requires regular emollient therapy to maintain skin hydration, reduce itching or discomfort, and prevent skin breakdown or flare-ups of skin conditions (e.g., eczema, dermatitis, psoriasis).

Planned Outcome wording examples…
• Creams are applied as prescribed to maintain or improve skin condition. • Skin remains intact, healthy, and free from irritation or breakdown. • The individual is comfortable and free from itching or discomfort. • Compliance with prescribed treatment is achieved. • Skin remains soft, hydrated, and intact. • Discomfort from dryness, itching, or irritation is reduced. • Risk of skin breakdown, infection, or deterioration is minimised. • Emollients are applied consistently and safely as prescribed.

How to achieve Outcome…

- All topical treatments must be recorded on the MAR chart and applied in accordance with GP or specialist instructions.
- Creams are to be applied using gloves to prevent cross-contamination.
- Staff must document the time, area of application, and initials after each use.
- Follow any frequency and specific guidance (e.g. "apply thinly", "rub in completely", "avoid broken skin").
- Observe for any adverse reactions (e.g., redness, rash, discomfort) and report to the Senior or GP.
- Ensure the skin is clean and dry before application.
- Respect the individual's privacy and dignity during application.
- Explain the procedure to the individual before each application and gain consent.
- Encourage the individual to be involved if able and willing, promoting independence.
- Prescribed emollient to be applied as per the GP or specialist instructions - please refer to Camascope.
- Ensure hands are clean or gloves are worn before application to prevent infection or contamination.
- Apply emollient to the whole body or specified areas (e.g., arms, legs, back) as per Camascope.
- Do not apply to broken or infected skin unless specifically prescribed.
- Allow emollient to absorb fully before applying other topical treatments if prescribed.
- Reapply emollient after bathing or showering, once the skin is gently patted dry.
- Document all applications on the MAR or topical medication record sheet.
- Observe for any signs of irritation, allergic reaction, or changes in skin condition and report to the Senior or GP.
- Ensure safe storage of emollients to prevent contamination.
- Involve the individual where possible in their own skincare routine to promote independence and dignity.
- Maintain privacy and dignity during application.
- Ensure bed linen is washed at least twice a week in accordance to the guidance.
- Ensure clothing is changed daily.

Risks to be considered…

- **Fire Risk:** Emollients, particularly paraffin-based, can soak into clothing and bedding and become flammable. Advise against smoking or naked flames near treated skin. Change clothing and bedding regularly.
- Ensure all staff are aware of the fire risk associated with emollient use.

Risks additional notes…

- You should also remember that it is important to set-up a personalised interaction for Linen changes.

Eating and Drinking

Supporting individuals with eating and drinking is a vital part of promoting health, wellbeing, and quality of life. Good nutrition and hydration not only meet physical needs but also provide comfort, enjoyment, and opportunities for social interaction.

This section of the guidance sets out how to record individual preferences, dietary requirements, and any risks related to eating or swallowing. It also highlights the importance of dignity, choice, and cultural considerations in ensuring that support with meals and fluids is safe, person-centred, and respectful.

Identified Need wording examples…

- Requires support with eating due to physical limitations eg. individual has limited hand mobility and cannot feed themselves independently.
- At risk of malnutrition or weight loss eg. individual has a low BMI and poor appetite, requiring nutritional monitoring.
- Swallowing difficulties (dysphagia) eg. individual is at risk of choking and requires texture -modified diet and/or thickened fluids.
- Requires assistance to ensure adequate fluid intake eg. individual forgets to drink and is at risk of dehydration.
- Diabetic dietary requirements eg. individual requires a balanced diet low in sugar to manage type 2 diabetes.
- Cultural, religious, or personal dietary preferences eg. individual follows a vegetarian diet and avoids pork and beef for religious reasons.
- Cognitive impairment affecting eating habits eg. individual with dementia may forget they have eaten or not recognise food items.
- Oral health issues affecting eating ability eg. individual has poorly fitting dentures causing difficulty chewing food.
- Requires prompting or encouragement to eat eg. individual is often distracted or lacks motivation to eat meals without support.
- Modified equipment needed eg. individual needs a plate guard and adapted cutlery to promote independent eating.

Identified Need additional notes to consider…

- What type of diet and fluids do they require? eg. IDDSI level details - texture-modified diet and/or thickened fluids.
- How many scoops of thickener in 200mls?
- Nil By mouth and requires PEG/NG feeding? (refer to PEG plan if applicable)
- Do they have any food allergies/intolerances or need to avoid certain food or drinks due to their medication?

Planned Outcome wording examples…

- Individual maintains adequate nutritional intake with dignity and comfort.
- Individual's weight is maintained or improved over time.
- Individual eats and drinks safely without risk of choking or aspiration.
- Individual's blood glucose levels are maintained within target range - please see Health CarePlan.

How to achieve Outcome…

- Provide full assistance with feeding at each mealtime.
- Ensure food is cut into manageable pieces before serving.
- Offer choices and involve the individual in mealtime decisions where possible.
- Position individual upright and support posture throughout feeding.
- Record food intake on daily charts to monitor adequacy.
- Offer small, frequent meals and high-calorie snacks.
- Fortify foods with cream, butter, or supplements as advised by dietitian.
- Monitor weight weekly and review with clinical team monthly.
- Record food intake and escalate concerns if consistently low.
- Provide encouragement and a calm environment during meals.
- Follow Speech and Language Therapy (SaLT) guidance for texture and consistency.
- Use thickening powder in all fluids as per IDDSI level prescribed.
- Monitor for signs of swallowing difficulty (e.g., coughing, wet voice).
- Supervise all meals and drinks; do not leave individual unattended while eating or drinking.
- Keep emergency suction equipment available as per Care Plan. (Nursing only)
- Offer drinks at regular intervals (at least 8 cups daily).
- Provide preferred drinks and present attractively (e.g., coloured cups, with straws).

- Encourage fluids with medication and between meals.
- Record daily fluid intake and escalate if under *****ml.
- Observe for signs of dehydration (dry mouth, confusion, reduced urine output).
- Ensure meals align with diabetic dietary requirements (low sugar, controlled carbs).
- Monitor blood glucose levels as prescribed.
- Avoid sugary snacks unless clinically advised (e.g., for hypoglycaemia).
- Liaise with kitchen to ensure correct meals are provided.
- Educate staff on diabetes-friendly options and mealtime routines.
- What assistance do they require?
- Can they manage to eat independently, need their food cutting, encouragement, supervision, assisting to eat whilst they walk or are they fully dependent on staff?
- Are any specific cutlery or crockery, or drinking aids such as straws or beakers required?
- Do they need hot drinks cooled in case of scalding?
- Where do they eat their meals?
- Do they sit in a specialist/dining or wheelchair?
- What position do they need to be in when eating and drinking?
- How do staff support them with handwashing and protecting their clothes?
- What size portion do they like/need?
- Is any food/drink fortification required and how is this provided? (refer to plan for nutrition or weight loss if applicable)
- What is their ability to choose from the menu verbally or visually?
- Is food and fluid monitoring required?
- What is their fluid intake target?
- Are there any fluid restrictions?
- What action needs to be taken if fluid target is not met?
- How often should they be weighed?
- Under what circumstances would you refer them to a dietician or Speech and Language Team (SaLT)?

Elimination

Elimination is a fundamental aspect of health and wellbeing, and supporting individuals with their continence needs requires sensitivity, respect, and careful planning. Effective care in this area helps maintain dignity, comfort, and independence while also reducing the risk of complications such as skin breakdown, infection, or dehydration.

This section provides guidance on documenting routines and preferences, and details of implemented strategies that promote privacy, safety, and person-centred care.

Identified Need wording examples…

- Reduced bladder control requiring assistance with toileting and continence products.
- Risk of constipation due to limited mobility and reduced fluid intake.
- Requires prompting or physical support to use the toilet due to cognitive impairment or physical disability.
- Use of a catheter or stoma and needs support with hygiene and maintenance.
- Experiences urgency or frequency and requires quick access to a toilet.
- At risk of incontinence-associated skin damage and needs regular toileting and skin care routines.
- Embarrassment or distress related to incontinence that affects dignity and emotional wellbeing.
- Individual has an in-dwelling urinary catheter in place to support bladder drainage. Requires support to maintain catheter hygiene, prevent infection, and ensure comfort and dignity.
- Individual has a stoma and requires support from staff to manage it safely and hygienically. eg. I may need assistance with changing my stoma bag and ensuring the surrounding skin is clean and intact. I am at risk of skin breakdown or infection if the stoma area is not maintained properly.

Identified Need additional notes to consider…

- Do they have a history of urine infections?
- What can the individual do to manage their own continence and what assistance/encouragement do they need?

Planned Outcome wording examples…

- Remains clean, dry, and comfortable throughout the day and night.
- Skin remains healthy and free from breakdown or irritation.
- Feels supported and dignified in managing their continence needs.
- The individual maintains regular and comfortable bowel movements.
- Provide privacy and dignity during toileting and ensure timely access to toilet/commode .
- To maintain the individual's comfort and dignity.
- To reduce the risk of urinary tract infections (UTIs).
- To promote good catheter hygiene and skin integrity.
- To ensure catheter is draining effectively and appropriately.
- To maintain good stoma hygiene and skin integrity.
- To prevent any complications such as infection, leakage, or soreness.

How to achieve Outcome…

- Provide personal care discreetly and respectfully after each episode of incontinence.
- Offer toileting opportunities at least every 2–3 hours and as needed.
- Use appropriate continence aids (e.g., pads, pull-ups) as assessed.
- Monitor fluid intake and encourage adequate hydration throughout the day.
- Complete and review a continence assessment 6 monthly or sooner if needed.
- Monitor skin condition daily; apply barrier creams if prescribed.
- Ensure regular access to the toilet, especially after meals and before bed.
- Note pad type and size, frequency of continence care , are barrier creams used and how often should they be used - (refer to catheter/stoma plan if applicable)
- What assistance or prompting do they need to maintain continence?
- Monitor bowel movements (specify how often depending on needs of individual).
- Encourage a high-fibre diet where appropriate (fruits, vegetables, whole grains).
- Promote adequate fluid intake (aim for 6–8 cups of fluid daily unless restricted).
- Encourage or assist with regular mobility and light physical activity.
- Review medications for constipating side effects and liaise with GP/pharmacist if needed.
- Administer prescribed laxatives as directed and review effectiveness.
- Observe for signs of constipation or impaction (abdominal pain, nausea, refusal to eat).
- Record and report any concerns to senior staff or GP based on the individual.
- To reduce discomfort and symptoms associated with UTI.

- To monitor for and promptly respond to signs of deterioration or complications.
- To ensure prescribed antibiotics are taken as directed and completed.
- Staff to check catheter tubing and drainage bag each shift to ensure it is positioned correctly, draining freely, and not kinked or obstructed.
- Ensure catheter bag is secured below bladder level using appropriate straps or stands to prevent backflow.
- Support the individual with regular personal hygiene – clean the catheter entry site with warm water and mild, non-perfumed soap daily and after each bowel movement.
- Do not apply creams or powders near the catheter site unless prescribed.
- Monitor for signs of infection: cloudy or foul-smelling urine, pain or discomfort, fever, or leakage around the catheter site.
- Record catheter output on Nourish as per the fluid monitoring plan.
- Document any abnormalities such as blood in urine, blockage, or reduced output.
- Report any concerns immediately to the senior on duty or district nurse or nurse.
- Empty the catheter bag using a clean container at least every 6–8 hours or sooner if it is nearing full.
- Change night drainage bag daily and leg bag as per manufacturer's guidance or when visibly contaminated or malfunctioning.
- Maintain a closed drainage system at all times unless clinically indicated otherwise.
- Specify if done by district nurse or trained clinical staff – e.g., "Catheter to be changed every 12 weeks by the district nurse team.".
- Record catheter change date, size, type, and batch number in clinical notes.
- Gain consent before catheter care is provided and explain each step.
- Staff to carefully remove the used stoma bag and dispose of it in clinical waste.
- Skin around the stoma to be cleaned gently using warm water and soft, non-perfumed wipes (no soaps or creams unless prescribed).
- Staff to inspect the stoma and surrounding skin for any signs of redness, irritation, or breakdown and report concerns to the nurse or senior staff.
- New stoma bag to be applied as per the type and instructions (ensure correct fit and secure seal).
- Use of barrier creams or powders if prescribed and necessary.
- Staff to document any abnormalities, such as: bleeding from the stoma, change in output (consistency, frequency, colour) and/or skin issues around the stoma.

Health

Promoting and maintaining health is a core element of effective care planning. Each individual's health needs are unique and may include ongoing medical conditions, preventive care, or support to access healthcare services. A well-developed health plan ensures that physical wellbeing is considered alongside treatment and lifestyle needs.

This section provides guidance on recording essential information, such as details of partnerships with healthcare professionals that allow us to deliver safe, consistent, and person-centred support.

Identified Need wording examples…

- Management of chronic conditions eg. individual has Type 2 Diabetes requiring regular blood glucose monitoring and medication.
- Monitoring of vital signs eg. individual is at risk of hypertension and needs regular blood pressure monitoring.
- Nutritional health eg. individual has unintentional weight loss and requires high-calorie, fortified meals and regular weight monitoring.
- Risk of infection eg. individual has a catheter in situ and is at risk of urinary tract infections.
- Pain management eg. individual experiences chronic arthritis pain and requires regular analgesia and monitoring.
- Monitoring for deterioration or relapse eg. individual has COPD and needs monitoring for shortness of breath and oxygen saturation levels.
- Individual is at risk of hypoglycaemia due to use of insulin or oral diabetes medication.
- Individual is at risk of hyperglycaemia due to missed medication or uncontrolled diet.
- Individual is at risk of foot complications due to reduced sensation and circulation.
- Individual has a diagnosis of epilepsy and is at risk of having seizures.
- Individual is at risk of injury during a seizure (e.g. falls, hitting objects).
- Individual has a diagnosis of Parkinson's disease - a progressive neurological condition affecting movement, coordination, and sometimes cognitive ability. This may result in tremors, muscle stiffness, slowness of movement, postural instability, fatigue, speech or swallowing difficulties, and emotional changes.

Identified Need additional notes to consider…

- List any conditions that require regular treatments e.g. persistent urine infections, constipation…
- Include all allergies/intolerance to medication, food, latex, dressings, vaccinations etc and, if known, the details and severity of the reaction experienced
- **Remember – there is no need to list Medical Conditions. Please signpost to the 'Critical Information' page…**

Planned Outcome wording examples…

- Pain is managed effectively, allowing the individual to engage in daily activities.
- Individual maintains stable blood glucose levels within target range and avoids episodes of hypoglycaemia.
- Individual's blood glucose remains within target levels set by GP or diabetic nurse - please input level…
- Individual remains free from foot ulcers, injuries, or infections.
- To reduce the frequency and severity of seizures and manage them safely when they occur.
- To minimise risk of physical injury during or following seizures.
- To manage Parkinson's symptoms effectively - please give details…
- To reduce the risk of falls and injuries.
- To support nutritional intake and prevent choking or aspiration.

How to achieve Outcome…

- Monitor blood glucose levels as per GP/diabetic nurse instructions - please give details…
- Administer insulin/oral medication as prescribed.
- Provide diabetic-friendly meals and snacks.
- Encourage fluid intake and exercise as appropriate.
- Record and report any signs of hypoglycaemia or hyperglycaemia to GP promptly.
- Administer prescribed pain relief medication regularly.
- Monitor pain levels using pain assessment tools.
- Encourage gentle movement and use of supportive equipment.
- Provide comfort measures such as warm packs or adjusted positioning.
- Liaise with GP if pain escalates or becomes unmanageable.
- Ensure meals are provided regularly and not missed.
- Educate staff on signs of low blood sugar (sweating, confusion, shakiness).
- Keep fast-acting glucose (e.g. juice, glucose tablets) available at all times.
- Administer medication as prescribed.
- Promote a balanced diabetic-friendly diet.
- Monitor for signs of high blood sugar (e.g. increased thirst, urination, drowsiness).
- Notify healthcare professional of repeated abnormal readings. Perform and document foot checks - please specify how often…
- Ensure appropriate footwear is worn.
- Provide footcare.
- Refer to podiatry as needed.

- Ensure staff to report redness, cuts, or signs of infection promptly.
- Administer anti-epileptic medication as prescribed and monitor for side effects.
- Keep a seizure log to record date, time, duration, and type of seizure.
- Ensure care staff are trained in epilepsy awareness and seizure first aid.
- Identify and avoid known triggers (e.g., stress, missed medication, lack of sleep).
- Regular medical reviews with GP or neurologist.
- Ensure a safe environment (e.g. remove sharp edges, use crash mats if needed).
- Support during personal care or mobilising if recent seizure activity noted.
- Use falls prevention equipment where appropriate.
- Supervise closely during known periods of increased seizure activity.
- Encourage slow, steady movements; avoid rushing the individual.
- Ensure medication is administered at the correct times consistently to manage symptoms (particularly levodopa-based drugs).
- Monitor for signs of dysphagia (difficulty swallowing).

Maintaining a Safe Environment

Ensuring a safe environment is essential to protecting individuals from avoidable harm and supporting their overall wellbeing. A safe setting not only reduces risks such as accidents, infections, and hazards but also promotes confidence, comfort, and independence.

This section outlines best practice in recording identified and managed environmental risks, balancing safety with personal choice, and ensuring that homes and care settings remain supportive, accessible, and responsive to changing needs.

Identified Need wording examples…

- Risk of falls due to impaired mobility or balance eg. individual has unsteady gait and is at high risk of falls.
- Impaired vision or hearing affecting awareness of surroundings eg. individual has poor vision and may not see hazards in their environment.
- Individual has cognitive impairment (dementia) and is at risk of wandering into unsafe areas or leaving the building.
- Risk of injury when using mobility aids or equipment eg. individual uses a walking frame but does not always use it correctly.
- Fire safety awareness and evacuation challenges eg. individual would be unable to evacuate safely without support.
- Inadequate awareness of personal boundaries or safety rules eg. individual frequently enters others' rooms, which could cause distress or lead to conflict.
- Medication side effects increasing safety risks eg. medication may cause drowsiness, increasing fall risk.
- Individual is at risk of fire when smoking due to reduced awareness, mobility, or care environment.
- Individual is at risk of oxygen-related hazards, including fire or incorrect usage.

Planned Outcome wording examples…

- Individual remains safe from falls and is supported to mobilise confidently and securely.
- Individual is safely supported within the home and is protected from harm related to wandering.
- Individual moves safely around their environment without incident or injury.
- To ensure smoking is carried out in a safe and controlled environment to prevent fire risk.
- Individual and others remain safe when oxygen therapy is in use.

How to achieve Outcome…

- Ensure call bell is within reach at all times.
- Place furniture to create clear walkways.
- Encourage the use of prescribed mobility aid (e.g., walking frame) for all transfers.
- Complete regular environment safety checks (trip hazards, wet floors).
- Observe and assist with all transfers as per moving and handling risk assessment.
- Encourage appropriate footwear with non-slip soles.
- Document and report any incidents or near misses.
- Ensure secure entry/exit points and monitor resident location - please give timescales…
- Use discreet signage and visual cues to encourage safe pathways.
- Engage the individual in meaningful activities to reduce restlessness.
- Supervise during periods of increased risk (e.g., shift changes, evenings).
- Care team to document behaviours and triggers in daily notes.
- Liaise with GP if patterns of wandering increase to review care strategies.
- Ensure good lighting in all areas, especially at night (eg. nightlights if needed).
- Maintain clutter-free floor spaces and ensure items are not left in walkways.
- Report and clean any spills promptly.
- Encourage use of glasses and ensure they are clean and correctly fitted.
- Staff to guide the individual where necessary and monitor for environmental risks.
- Ensure smoking takes place only in designated smoking areas.
- Risk assess smoking habits regularly.
- Provide supervision or support with smoking if cognitive or physical risks are present.
- Never allow smoking in bed or unsupervised areas.
- Ensure fire safety measures are in place (fire-retardant aprons, safe ashtrays, no oxygen nearby).
- Ensure oxygen is stored and used according to health and safety guidance.
- Display “Oxygen in Use – No Smoking” signs clearly where oxygen is used.
- Strictly prohibit smoking, open flames, or heat sources near oxygen equipment.
- Check for compatibility of materials (e.g. avoid oil-based creams near oxygen).
- Ensure Welfare checks are carried out - please give details and reason why…

Managing Medication

Safe and effective medication management is a vital part of many care plans and plays a key role in maintaining health, preventing illness, and managing ongoing conditions. Supporting individuals with their medicines requires accuracy, consistency, and clear communication to ensure the right person receives the right medication, in the right dose, at the right time.

This section provides guidance on recording how to store, administer, and review medication in line with professional standards and legal requirements, while also respecting individual preferences and promoting independence wherever possible.

Identified Need wording examples…

- Requires support to administer prescribed medication safely and correctly e.g., due to memory loss, physical limitations, or risk of overdose.
- Needs assistance to understand the purpose and side effects of medication.
- Needs regular monitoring for side effects or effectiveness of medication.
- Has allergies or sensitivities that must be considered in medication management.
- Needs support to manage complex medication regimes, including time-critical doses.
- Individual is prescribed anticoagulant medication (e.g., Warfarin, Apixaban, Rivaroxaban) to prevent blood clots due to a diagnosed condition such as atrial fibrillation, DVT, or pulmonary embolism. This places the individual at increased risk of bleeding, interactions with other medications, and requires careful monitoring.
- The individual lacks the mental capacity to make informed decisions about their medication and is refusing essential prescribed medication, which could lead to deterioration in their physical and/or mental health.
- Individual self-medicates.

Identified Need additional notes to consider…

- **Remember – there is no need to list Medications. Please signpost to 'Camoscope'…**

Planned Outcome wording examples…

- Individual receives all prescribed medication safely and at the correct times.
- Individual remains free from harm caused by missed, incorrect, or duplicate medication.
- Any side effects or adverse reactions are identified early and responded to appropriately.
- Individual's medications are stored securely and are only accessible to authorised staff.
- The individual remains safe while on anticoagulant therapy.
- Any signs of bleeding or adverse effects are promptly recognised and managed.
- The individual maintains therapeutic levels (if on Warfarin).
- Staff are aware of and follow correct protocols for administration and monitoring.
- The individual receives prescribed medication in a safe and ethical manner to maintain or improve their health and well-being, while ensuring compliance with legal and professional frameworks.
- To ensure they are managing their medication as per the prescription (self-medication).

How to achieve Outcome…

- All medication to be administered by trained and competent staff in accordance with the MAR (Medication Administration Record).
- Staff to follow the home's medication policy, including double-checking any PRN (as needed) or controlled drugs.
- Ensure all medications are securely stored in a locked cabinet or medication trolley as per guidelines.
- Observe for side effects or changes in condition; document and report promptly to the GP or prescribing team.
- Understand how the individual likes to take the medication.
- Regularly review medication with GP or pharmacist (e.g., annual medication review or sooner if needed).
- Involve the individual (where capacity allows) in discussions about their medication to support informed consent and understanding.
- Maintain clear documentation and record-keeping, including missed doses, refusals, or changes.
- Ensure the individual's anticoagulant medication is administered as prescribed, at the correct time.
- Monitor for any signs of bleeding (e.g., bruising, nosebleeds, bleeding gums, blood in urine or stools).
- Record and report any adverse effects or signs of bleeding immediately to a GP.
- Warfarin: Ensure INR levels are monitored as per GP instruction and results are recorded clearly in the MAR chart and care plan.
- DOACs (e.g., Apixaban, Rivaroxaban): Follow GP guidance and monitor renal function as required.
- Liaise regularly with GP, pharmacy, and anticoagulation clinic (if involved).
- Ensure staff are trained and competent in anticoagulation awareness and medication management.

- Notify healthcare professionals before any invasive procedure or new medication is started , to check for interactions or the need to adjust dosage.
- Ensure fall risk assessments are up to date, as falls can pose increased danger due to risk of internal bleeding.
- Communicate the anticoagulation status clearly during hospital admission or external appointments.
- A Best Interest Decision has been made in accordance with the Mental Capacity Act (2005), involving relevant professionals and family/advocates where appropriate.
- A Covert Medication Pathway has been followed, and the decision is documented clearly in the individual's notes.
- A Covert Medication Authorisation Form has been completed and signed by the GP, pharmacist, and care home manager.
- The method of concealment (e.g., in food or drink) is agreed upon by the pharmacist to ensure the efficacy and safety of the medication.
- Only trained staff administer medication covertly, following the agreed protocol.
- Medication is administered covertly only when refusal is confirmed and in line with the care plan instructions.
- The decision is regularly reviewed (at least monthly or sooner if the individual's condition changes) in multidisciplinary meetings.
- Staff must continue to offer medication openly and encourage compliance before using the covert approach.
- Accurate records are maintained for each administration, noting the reason for covert administration.
- The individual's dignity, preferences, and rights are respected at all times.
- Ensure weekly stock checks are undertaken for self-medicating residents and report any abnormalities.

Mental Health

Mental health is a fundamental part of overall wellbeing and should be considered with the same importance as physical health when developing care plans. Effective care planning for mental health involves recognising individual needs, promoting strengths, and supporting recovery in a way that respects dignity, choice, and independence. This requires a person-centred approach that considers the individual's experiences, preferences, and aspirations, while also addressing potential risks and safeguarding concerns.

This section provides guidance on recording essential information, such as details of partnerships with healthcare professionals that allow us to deliver safe, consistent, and person-centred support.

Identified Need wording examples…

- Support to manage symptoms of mental illness e.g. persistent low mood, anxiety, hallucinations, delusions, or mood instability.
- Assistance with emotional regulation and development of coping strategies e.g. difficulty managing anger, stress, or overwhelming emotions.
- Monitoring and support with mental health medication e.g. to ensure adherence, manage side effects, or address refusal — especially where capacity to make decisions may fluctuate.
- Support with daily routines and personal care where mental health impacts motivation or functioning e.g. lack of motivation due to depression or disorganised thinking in psychosis.
- Support to assess and monitor capacity for specific decisions e.g. treatment, finances, care planning.
- Support to make decisions in line with the Mental Capacity Act (2005), ensuring best interests are followed when capacity is lacking e.g. involving the individual as much as possible and applying the least restrictive option.
- Risk reduction support for self-harm, suicidal ideation, or risk to others e.g. through close monitoring, emotional support, and involvement of the MDT.
- Help with maintaining social relationships and reducing isolation e.g. support to engage in community activities or rebuild family contact.
- Encouragement and support to attend health or therapeutic appointments e.g. where the individual avoids or forgets due to anxiety or cognitive difficulties.
- Support with insight into condition and informed engagement in treatment decisions e.g. psychoeducation or involvement of an advocate if capacity is impaired.
- Support to manage triggers, prevent relapse, and maintain mental stability e.g. using relapse prevention plans, early warning signs monitoring.
- The individual is living with dementia, which affects their memory, cognitive function, and ability to make decisions, leading to confusion, anxiety, and changes in mood and behaviour.

- The individual lacks insight into their condition and may struggle to understand or accept care interventions, leading to resistance or distress.
- The individual may lack capacity in some areas of decision-making due to dementia progression.
- The individual is living with early-stage dementia but retains capacity to make decisions and express their wishes. They may experience anxiety or frustration about memory loss and changes in cognition.
- The individual has capacity.
- The individual lacks the mental capacity to consent to their care and accommodation arrangements, and is subject to continuous supervision and control and is not free to leave the care setting. These restrictions may amount to a deprivation of liberty.

Planned Outcome wording examples…

- The individual maintains mental stability and experiences reduced distress from symptoms.
- The individual uses safe coping strategies and experiences reduced emotional outbursts.
- The individual adheres to prescribed medication regime safely and consistently.
- Capacity assessments are completed as needed, and decisions are made in the individual's best interest where required.
- The individual remains safe and is supported during periods of risk.
- The individual has regular positive social interaction and feels less isolated.
- The individual experiences emotional wellbeing and feels safe, understood, and supported despite cognitive decline.
- The individual accepts support and interventions in a calm and cooperative manner.
- All decisions are made in the best interest of the individual, respecting legal frameworks.
- The individual feels supported, emotionally stable, and in control of their care and daily life.
- The individual maintains emotional stability and mental wellbeing.
- The individual remains involved in decisions about their care and support.
- The individual feels listened to, respected, and supported in a way that promotes independence and dignity.
- To ensure the individual's rights are upheld in accordance with the Mental Capacity Act 2005 and DoLS framework, and that care is delivered in the least restrictive manner while promoting safety, dignity, and wellbeing.

How to achieve Outcome…

- Ensure prescribed medication is taken consistently and monitor for side effects.
- Provide emotional support and reassurance during episodes of distress.
- Involve mental health professionals (e.g., CPN, psychiatrist) in regular reviews.
- Use distraction techniques or grounding strategies during episodes of anxiety or hallucination.
- Encourage use of coping strategies such as journaling, breathing exercises, or mindfulness.
- Offer regular emotional check-ins with staff.
- Provide calm, structured routines to reduce stress.
- Administer medication as prescribed and record accurately.
- Monitor for side effects and communicate concerns with the GP/psychiatrist.
- Educate the individual on the benefits of medication to encourage compliance.
- Carry out formal capacity assessments for key decisions (e.g., treatment, finances, care planning).
- Record assessments and ensure staff follow MCA guidelines.
- Involve family, advocates, and the MDT where appropriate.
- Monitor mood and behaviours regularly and record concerns.
- Complete risk assessments and update safety plans as needed.
- Provide immediate support and seek mental health crisis intervention if risk escalates.
- Engage in regular 1:1 session to explore feelings and triggers.
- Encourage participation in group activities or community events.
- Support contact with family and friends.
- Promote hobbies and interests that involve interaction.
- Encourage engagement in meaningful activities to reduce isolation and agitation.
- Monitor for signs of distress, depression, or behavioural changes, and escalate to GP/mental health team if needed.
- Promote involvement in decisions wherever possible to support autonomy.
- Ensure regular reviews of capacity and involve advocates or family as appropriate.
- Use validation techniques rather than challenging beliefs.
- Introduce care tasks in a non-confrontational, person-centred way.
- Observe and respond to non-verbal cues of discomfort or anxiety.
- Offer choices to promote a sense of control.
- Use distraction or redirection when appropriate to avoid conflict.
- Involve family or familiar persons when introducing new routines.
- Complete a mental capacity assessment for relevant decisions.
- Record outcomes and ensure decisions are made in line with the Mental Capacity Act 2005.
- Involve family, advocates, and multidisciplinary team as required.

- Ensure any restrictions are the least restrictive and proportionate to the risk.
- Review decisions regularly as capacity may fluctuate.
- A current DoLS authorisation must be in place and kept under regular review.
- Any conditions attached to the authorisation must be fully understood and followed by staff - please give details.
- Any changes in the individual's condition or care arrangements that may affect the deprivation of liberty must be reported promptly to the senior team, and a review or urgent DoLS application made if required.
- Staff must deliver care in the least restrictive way, seeking to maximise the individual's independence and choices wherever possible.

Important Note…

- A copy of the DoLS authorisation and any associated documents (including Form 3 – Best Interests Assessment and Form 5 – Conditions) must be available in the care file and on the digital care system.

Mobilising

Supporting an individual's ability to move safely and confidently is a vital part of maintaining independence, dignity, and quality of life. Care planning for mobilising should consider both the individual's current level of mobility and their potential to improve or maintain it, considering medical conditions, risks, preferences, and daily routines.

This section provides guidance on recording essential information, including assessments of mobility needs, agreed strategies for safe movement, and details of any equipment, adaptations, or support required. It also highlights the importance of working in partnership with physiotherapists, occupational therapists, and other professionals to ensure that mobility support is consistent, person-centred, and promotes wellbeing.

Identified Need wording examples…

- The individual has reduced mobility and is at risk of falls.
- The individual is non-weight bearing and requires full support with all transfers.
- The individual uses a walking aid but experiences occasional unsteadiness.
- The individual has limited lower limb strength and cannot mobilise without assistance.
- The individual can mobilise independently indoors but needs support outdoors due to visual impairment and uneven terrain.
- The individual requires the use of a hoist for safe transfers due to physical frailty and lack of balance.
- The individual's cognitive impairment impacts their ability to mobilise safely without supervision.
- Previous incidents e.g. history of falls or near misses.
- Is the person at risk of falls?
- Are they able to weight bear?

Planned Outcome wording examples…

- To mobilise safely around the home using a walking aid with minimal assistance.
- To maintain current level of mobility and prevent further decline.
- To transfer safely from bed to chair using a hoist with support from two carers.
- To participate in daily movement exercises to improve lower limb strength and balance.
- To reduce risk of falls through appropriate equipment use and staff support.
- To attend communal areas daily with support to encourage social interaction and movement.
- To be repositioned regularly to prevent pressure injuries and maintain comfort.

How to achieve Outcome…

- Environmental hazards e.g. cluttered walkways, uneven flooring.
- Specific equipment required e.g. type/size of hoist, sling, walking aid.
- Number of staff required for support e.g. 1 or 2 carers.
- Type of support needed e.g. guiding hand, full transfer.
- Gender preference for staff during personal care or transfers (if applicable).
- Promoting independence as much as safely possible.
- Positioning for comfort and pressure area care.
- Repositioning schedule (if bed-bound).
- Preferences for movement e.g. walking to meals, joining activities.
- Engagement in mobility-related routines.
- How do they move from one room to another?
- What assistance is required for standing, walking, transferring?
- What information do staff need to provide when assisting them?
- Is any equipment required?
- What type of hoist, and sling are required?
- What size sling and what loops should be used?
- Does the individual use a walking frame, tripod, walking stick, wheelchair?
- Do they own their own wheelchair, who services this for them, what are the contact details if there is a problem?
- Is any equipment required for moving longer distances or mobilising outside?
- Do they need repositioning, how often and what equipment is required for this?
- How compliant are they with the use of equipment and repositioning requirements?
- Is any of the following equipment used - Bedrails, Sensor mat, Movement sensor, Bed sensor, Chair sensor, Hip protectors, Leg Callipers?
- What do they wear on their feet?
- When would you make a referral to the physio, OT or falls team?
- Record any Physio, OT, falls team input and guidance or refer to their report.

Personal Care and Dressing

Personal care and dressing are essential aspects of daily living that contribute to an individual's comfort, dignity, and sense of identity. Care planning in this area should focus on supporting independence wherever possible, while providing sensitive and respectful assistance where needed.

This section provides guidance on recording essential information, such as personal preferences, routines, and cultural or religious considerations, as well as any equipment, adaptations, or professional input required to deliver safe and consistent support. By taking a person-centred approach, practitioners can ensure that personal care and dressing are carried out in ways that uphold privacy, promote choice, and enhance overall wellbeing.

Identified Need wording examples…

- Assistance with washing and bathing due to limited mobility or cognitive impairment.
- Support with dressing to ensure appropriate clothing and personal dignity.
- Ensure the individual remains as independent as possible.
- Help with oral care to maintain hygiene and prevent infections.
- Skin care needs due to risk of pressure sores or dry skin.
- Assistance with grooming (hair care, shaving, nail care) to promote self-esteem.
- Incontinence care to manage hygiene and comfort effectively.
- Support with menstrual care, if applicable…
- Cultural or religious preferences related to personal care routines.

Identified Need additional notes to consider…

- What assistance does the individual require with their oral hygiene?
- If the individual has dentures, can they look after themselves or do staff need to clean/soak them and how often?
- If the individual has their own teeth can they clean them themselves or do they need staff to help/encourage them and how often?
- Does the individual prefer which gender of carer assists them with personal care?
- Does the individual find assistance with personal care difficult? (refer to mental health care plan if appropriate).
- Does the individual prefer a bath/shower/bed bath and how often?
- If the individual generally has a wash in bed, how often should they have a bath/shower?
- Is the individual able to make choices regarding their clothing and what preferences do they have?

Planned Outcome wording examples…

- The individual remains clean, fresh, and safe, with dignity and privacy maintained during personal care.
- The individual is comfortably dressed in weather- and occasion-appropriate clothing, promoting self-esteem.
- Mouth and teeth remain clean and healthy, reducing risk of dental issues.
- Individual remains clean, dry, and comfortable, with risk of infection or skin breakdown reduced.
- Individual feels well-presented and confident.
- To remain as independent as possible.

How to achieve Outcome…

- Provide support with bathing or showering daily, or as per preference.
- Use shower chair or bath lift as required.
- Two carers to support where needed for safety.
- Ensure bathroom is warm and non-slip mats are used.
- Monitor skin condition during care.
- Offer choice of clothing daily.
- Support dressing in a way that maintains dignity.
- Use adaptive clothing if needed for ease.
- Support with brushing teeth twice daily or denture care.
- Offer mouthwash or flossing support if accepted.
- Record any issues such as soreness or bleeding.
- Regular toileting and prompt pad changes as per continence assessment.
- Monitor for skin integrity and signs of infection.
- Use barrier creams where prescribed.
- Assist with brushing hair daily.
- Support shaving, nail care and booking hair appointments as preferred.
- Respect cultural or personal style preferences.
- How many staff are required to assist the individual with their personal care?
- Are any particular toiletries required, such as soap substitutes, deodorant or creams to reduce skin irritation?
- What type/brand of toiletries does the individual prefer?
- Where are their toiletries kept?
- Is it safe for toiletries and grooming products to be readily accessible to them?
- Do they wear tights/stockings/socks?

- How do they like to look and what level of support they require to achieve this? Consider: Hair, facial hair, make up, perfume/aftershave, jewellery…
- What assistance do they require with nail care, keeping them clean/cut? Who trims finger/toe nails?
- Do they see a chiropodist or podiatrist?
- How are their feet kept clean and in a good condition? Do they require cream to keep the skin soft?
- Do staff need to observe the person's skin for signs of pressure damage, moisture lesions, bruises, other skin conditions? - refer to the skincare plan…

Skin

Maintaining healthy skin is a key part of overall wellbeing and an important focus in care planning. Good skin care helps prevent discomfort, infection, and more serious complications, while also supporting dignity and quality of life.

This section provides guidance on recording essential information, including individual skin care needs, risks such as pressure damage or dryness, and agreed strategies for monitoring and maintaining skin integrity.

Identified Need wording examples…
• The individual has fragile, thin skin and is at high risk of skin breakdown and pressure damage due to reduced mobility and continence issues. • Are there any medical skin conditions? eg. the individual has psoriasis. • The individual has a history of pressure ulcers or currently has a Category (insert Number) pressure sore. • The individual is incontinent and at risk of moisture-associated skin damage (MASD). • The individual has dry, flaky skin that requires regular moisturising to prevent cracking. • The individual is unable to reposition independently, increasing the risk of pressure injuries. • The individual has a medical condition e.g. diabetes, that affects skin healing and integrity. • Due to age-related changes, the individual has frail, thin, and fragile skin, increasing the risk of skin breakdown, tears, pressure damage, and delayed healing. • The individual has fragile skin and/or is on anticoagulant medication, placing them at increased risk of bruising even with minimal trauma or pressure.

Planned Outcome wording examples…
• The individual's skin remains intact, clean, and free from pressure damage, wounds or moisture-related injuries. • Risk of skin breakdown is minimised through proactive prevention and monitoring. • Any skin concerns are identified early and managed promptly. • The individual's skin is protected from unnecessary trauma. • Incidence of bruising is minimised. • Any bruising is promptly identified, monitored, and managed.

How to achieve Outcome…

- Conduct a full skin inspection daily and document any changes or concerns.
- Apply prescribed barrier cream to vulnerable areas (e.g., sacrum, buttocks, groin) during personal care.
- Reposition the individual at least every 2/4 hours using appropriate equipment such as pressure-relieving mattresses and cushions.
- Ensure the individual's skin is kept clean and dry after any episodes of incontinence. Use pH-balanced cleansers and avoid excessive rubbing.
- Maintain adequate hydration and nutritional intake to support skin integrity.
- Monitor for signs of pressure damage or moisture lesions and report concerns promptly to a senior or clinical lead.
- Involve the district nurse or tissue viability nurse for ongoing assessment if the skin is broken or deteriorating.
- Assess and document any existing bruises on admission or when new ones occur; review skin integrity daily.
- Use gentle handling techniques during all personal care and moving/handling tasks to avoid trauma.
- Avoid tight-fitting clothing or equipment (e.g., pressure from watch straps, bed rails, or cuffs) that may contribute to bruising.
- Apply protective padding to bed rails or other hard surfaces if risk is identified.
- Encourage independence with mobility, but supervise or assist when needed to prevent knocks or falls.
- Ensure use of appropriate mattresses/cushion (please give details), and ensure the setting required is recorded.
- Encourage hydration and nutrition to promote skin health and resilience.
- Ensure nails are trimmed and smooth to avoid scratching.
- Report and document any new bruises in line with safeguarding and internal reporting procedures.
- Review medications regularly with the GP or pharmacist, especially anticoagulants or steroids that may contribute to skin thinning and bruising.
- Educate staff and family on the individual's vulnerability to bruising and the importance of careful handling.

Wellbeing

Wellbeing is a broad and holistic concept that encompasses a person's physical, emotional, social, and spiritual needs. In care planning, promoting wellbeing means supporting not only health and safety, but also the things that bring meaning, purpose, and enjoyment to an individual's life.

This section provides guidance on recording essential information such as personal goals, interests, relationships, and cultural or religious preferences, alongside any professional input required.

Identified Need wording examples…

- To maintain and promote the individual's emotional, cultural, spiritual, and psychological wellbeing through personalised daily routines, meaningful engagement, and respect for their lifestyle preferences.
- [Name] enjoys [insert hobbies/interests, e.g., knitting, gardening, reading, puzzles].
- To ensure the individual is able to maintain their relationships with family and friends and to be able to portray themselves as they wish.
- For them to be given opportunities to develop new friendships and relationships.
- Is the individual single, in a relationship, married or widowed? Give details…

Planned Outcome wording examples…

- The individual feels valued, respected, and emotionally fulfilled.
- The individual experiences a meaningful day that reflects their interests, beliefs, and routines.
- The individual is supported to maintain or develop relationships and personal identity.

How to achieve Outcome…

- Prefers to wake at approximately [insert time] and go to bed around [insert time].
- Staff should support this routine unless health or safety concerns require adjustment.
- Encourage a calm evening routine to promote restful sleep.
- Offer regular opportunities to participate in these activities, either independently or with support.
- [Name] prefers [group/one-to-one/both] activities.
- Engage them in preferred formats of interaction, respecting their social comfort level.
- Tailor activity involvement based on mood and daily preference.
- Likes: [Insert preferences, e.g., music, certain foods, companionship].

- Dislikes: [Insert dislikes, e.g., loud noises, crowds, certain foods].
- Avoid triggers that may cause distress or discomfort.
- [Name] identifies as [insert religion/culture or 'non-religious' if applicable].
- They wish to observe [e.g., prayer times, dietary requirements, religious festivals].
- Facilitate access to religious services, visits from spiritual leaders, or time for private reflection as needed.
- [Name] enjoys spending the day [e.g., in the lounge, in their room, outdoors when weather permits].
- Encourage a daily routine that reflects their comfort and preferences.
- Offer choices about where to spend time and how they wish to structure their day.
- [Name] wishes to maintain [insert level of intimacy, e.g., close relationships, privacy for phone calls/visits, or expressions of affection].
- Staff must uphold dignity and provide a non-judgmental environment that supports personal identity and intimacy preferences.
- Respect privacy in all matters relating to relationships and sexual expression.
- How will they be supported to go out of the home? Do they need someone with them when they go out?
- Do they need assistance organising transport – such as booking a taxi?
- Do they have overnight stays' anywhere?
- Do they need an escort for hospital or other appointments?