Writing Good Care Plans

A practice guide for service users, carers and professionals
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1. Introduction

Purpose

This practice guide is intended to support good practice in Care Planning by mental health workers. It has been produced in collaboration with service users and carers and makes reference to current policy, guidance and recommendations, together with tips and suggestions about how to write a good Care Plan. This guidance:

· meets professional, local and national standards;

· clearly outlines aims, actions and responsibilities;

· supports Care Planning under the Care Programme Approach.

· interacts effectively with other care planning systems;

· and is accessible to everyone who is part of it.

Care Plan

A Care Plan 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
2. Where and how the care plan should be written

The approach to devising a care plan can often be as important as what is documented within it. The process of engaging with service users and carers to co-produce a care plan should be seen as a key intervention in its own right and is a key part of establishing and maintaining an effective relationship between a professional and a service user.

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.
3. Trust Care Planning Standards

The Trust has 12 care planning standards which were designed in conjunction with service users and carers to inform the most vital aspects of care planning:

1. Be service user focused and written in language that is clear
2. Be informed by the initial assessment formulation and on-going assessment of need
3. Encompass all needs identified
4. Be personalised and clearly build on service users strengths
5. Demonstrate that professionals are supporting service users and carers in playing a full role in the care
6. Be outcomes focused and demonstrate goals that show progress towards discharge and a focus on recovery
7. Where appropriate be multi-disciplinary and be one plan that follows the service user through care settings
8. Provide a record of needs identified
9. Clearly identify who is responsible for the delivery of
each element of care

10. Clearly state when each element of the care plan is to be reviewed (as a minimum this should be undertaken every six months)

11. Identify any unmet needs and ensure these are reported

12. Make reference to any advanced decisions or self-management plans

4. 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)
5. 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.
6. Advanced Statements

If you have a mental health condition, you may be worried that in the future you will not be able to make decisions for yourself due to mental illness. Some people choose to keep a record of how they would like to be treated, or not be treated, if they are ever in this position. When someone makes this kind of request or refusal, it is called an ‘advance statement’.

- **An advance statement is a way for you to say how you would like to be treated in the future if you ever lost the ability to decide for yourself**
- You can use an advance statement to say who you would like to manage other practical matters if you become ill, such as paying bills or looking after children.
- There are different types of advance statements which do different things.
- An **Advance Decision** is where you refuse certain types of treatment in the future. Only this sort of advance decision can be legally binding.
- Doctors should normally follow other advance statements though.
- If you would like to make an advance statement, speak to your care coordinator or lead professional who will be able to advise you.
7. 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.
8. 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 by others 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
The example below shows an approach to writing an effective care plan:

**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.
9. 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.
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.
10. Different types of care plan

There are a number of different care planning processes that may impact on people using health services, which can be confusing!

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 of care plan used across health and social care are provided below:

**Mental Health**

**Eligible/ Standard 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

**Care Programme Approach (CPA) Care Plan**

- 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 six months, with the date of the next review set in advance

**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 (for those who have previously been detained on a treatment Section of the Mental Health Act - Section 3,
37, 47 or 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:
o Transition from secondary education with a process for on-going referral;
o Leaving home to move into a residential service
o Moving home from one provider to another
o Moving to an out of area placement
o Changes in health status, for example as a result of a period of in-patient treatment
o On retirement
o When planning transition for those living with older family carers