



# Using Care Plans in Daily Support

Welcome to this guide on how to use care plans in your daily work. Care plans help you provide safe, person-centered care and are important legal documents.

In this presentation, we'll look at why care plans are important, what they contain, and how to record your care notes properly. You'll learn how to use care plans with confidence while keeping yourself and the people you support safe.

As carers, using care plans correctly helps you give good quality care that meets each person's needs and choices.

# Why Care Plans Matter



## Legal Documents

Care plans serve as legally binding documents that outline exactly how support should be provided.



## Essential Guide

They provide a comprehensive roadmap for delivering consistent, safe care appropriate to each individual.



## Protection

Following care plans protects the person receiving care, you as the carer, and your organisation.



## Documentation

Your notes must align with care plans, creating an accurate record of support provided.

Remember: If an action isn't specified in the care plan, it generally shouldn't be performed without proper authorisation. Care plans represent the agreed approach to supporting each individual's unique needs.

# CARE PLAN

## Needs / Problems

## Objectives

## Actions

## Review

# Key Sections of a Care Plan

Section	What You Should Know
Personal Info	Name, date of birth, GP details, emergency contacts
Communication	How they express needs, preferences, and what to observe
Health Needs	Diagnoses, allergies, medications, signs of pain or distress
Mobility	Transfer requirements, equipment needs, level of prompting
Preferences	Daily routines, likes/dislikes, preferred support methods
Risks	Falls assessment, refusal of care protocols, equipment safety

Each section of the care plan serves a specific purpose. Familiarise yourself with all sections to ensure comprehensive understanding of the person's needs. Pay particular attention to risks and preferences, as these guide your approach to delivering person-centred care.

## Care plan

Name	
Preferred name	
Room number	
Date of birth	
Date of admission	
Allergies	
Photo	

# Your Responsibilities as a Carer



## Read thoroughly

Review the complete care plan when assigned to a new person



## Follow exactly

Implement the plan precisely as written



## Raise concerns

Speak up about outdated or unclear information



## Record accurately

Document what actually happened, not routine events

Your role in implementing care plans is critical to maintaining quality care. Always take time to understand the specific requirements for each person you support. If something seems unclear or no longer appropriate, report this to your supervisor immediately.

Remember that care plans are dynamic documents that should evolve as the person's needs change. Your observations and feedback contribute to this process.

# Using Respectful Language

## Language to Avoid

- Suffering from dementia
- Refused again
- Wanders
- Difficult or challenging
- Non-compliant

## Preferred Language

- Living with dementia
- Declined support this morning
- Walked into kitchen area unsupervised
- Expressed strong preferences
- Made an informed choice

The language we use in care plans and daily notes reflects our attitudes and respect for those we support. Person-centred language acknowledges dignity, autonomy and individuality.

Always use clear, respectful, and non-judgmental language that focuses on the person, not just their condition or behaviour. This approach supports dignity and demonstrates professional care standards.

# Practical Scenarios

## Scenario 1: Changing Preferences

The care plan says Mr. J prefers tea with sugar. Today he asked for it without.

**Good response:** "Mr. J chose to have tea without sugar this morning. Supported his choice."

## Scenario 2: Declined Support

The care plan says Mrs. K needs support to shower. She refused today.

**Good response:** "Offered support with shower. Mrs. K declined. Reminded her it is available later if needed."

## Scenario 3: Unexpected Event

Mr. T has no history of falls, but you witnessed him stumble today.

**Good response:** "Mr. T momentarily lost balance when rising from chair at 10:15. No fall occurred. Observed for 30 minutes with no concerns. Reported to supervisor."

These scenarios illustrate how to respond professionally to common situations while maintaining proper documentation. Your notes should always be factual, specific, and directly related to the care plan.

Remember that changes in preferences or unexpected events should be documented and may indicate a need for care plan updates.

# Recording Effective Notes

**Match the care plan**  
Ensure notes reflect care plan requirements

**Avoid copying**  
Write fresh notes for each interaction



**Be specific**  
Include time, date and clear details

**Stay factual**  
Avoid opinions and subjective language

Effective documentation is crucial for continuity of care and legal protection. Your notes serve as evidence of the care provided and should be clear enough for someone who has never met the person to understand exactly what happened.

Remember the healthcare saying: "If it isn't written down, it didn't happen." Thorough documentation protects both you and the people you support in case questions arise about the care delivered.

# Key Takeaways for Daily Practice



As we conclude, remember that care plans are your essential guide to delivering safe, person-centred support. Use them at every visit, speak up when updates are needed, and document care accurately.

Don't make assumptions—always check the care plan. Your professional approach to using and following care plans demonstrates your commitment to high-quality care and supports positive outcomes for those you support.

Thank you for your dedication to providing excellent care through proper use of care plans.



# Learner Assessment



## Your Task: Care Note Scenario Response

Please complete the care note writing task by responding to a realistic scenario. This task will assess your understanding of:

- How to follow a care plan accurately
- Using respectful, person-centred language
- Recording care clearly and professionally
- Responding to the person's choices, needs, and risks



## Instructions:

1. Read the full scenario provided carefully.
2. Write a **detailed care note** based on what happened.
3. Include key actions, observations, choices, and outcomes.
4. Your note should read as if being recorded in the daily notes log.

👉 [Click here](#)



## What Happens Next:

- Your response will be reviewed.
- Feedback will be provided if improvements are needed.

✨ *This is your opportunity to demonstrate confidence and professionalism in using care plans to deliver outstanding care.*