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research article

Care planning in older adult care homes: a qualitative study of care staff experiences and views

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This study aims to understand how care planning is conducted in English older adult care homes and explore the views of staff involved in care planning. Drawing on 22 semi-structured interviews, the findings of the study are organised around five themes: the aims of care planning; conducting care planning; support and resources for care planning; the use of care planning information; and improving care planning. Our discussion notes the ways in which care staff would like to improve how care planning is conducted but highlights that a lack of resources may make improvement difficult.

Keywords: care homes • nursing homes • older people • care planning

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Introduction

The development of a care plan is a key part of the process of providing care and support in older adult care homes. A care plan outlines the type and level of care and support a resident requires and how this will be provided. It often includes information on such topics as medication, diet, interests and end-of-life preferences. Care plans are also recognised as an essential tool in ensuring high-quality care (NASEM, 2022). The information contained in standardised care plans can be used to assess the quality of care (Kuha et al, 2022). There is a growing trend across countries towards adopting a more person-centred approach in care planning in long-term care facilities (Koren, 2010; Wang et al, 2015; Lepore et al, 2018; Benette et al, 2020).

Several high-income countries encourage the engagement of residents and their families in the care-planning process and decision making regarding the daily care they receive. For example, in the US, these efforts are incorporated into federal regulations for Medicare- and Medicaid-funded nursing homes (CMS, 2016). Similarly, in the Netherlands, legal documentation mandates the development of individual care plans in consultation with residents or their legal representatives (Tuinman et al, 2017).

In England, around 300,000 people aged over 65 currently reside in older adult care homes (Office for National Statistics, 2023). Alongside accommodation, these homes provide care and support for daily activities like eating, washing, dressing and engaging in social interaction. In some care homes, usually referred to as 'nursing homes', nursing care is also provided. Those who reside in older adult care homes tend to have high levels of need,

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often living with long-term conditions and functional and cognitive decline (Oliver et al, 2014; Kingston et al, 2018). Analysis of mortality data to 2010 found that residents had a median life expectancy of 15 months from the date of admission (Forder and Fernandez, 2011), though this varies by location and provider (Steventon and Roberts, 2012), and that life expectancy has decreased over time (Espuny Pujol et al, 2021).

Section 9 of the Care Act 2014[1] requires English local authorities to conduct assessments where individuals may have a need for care and support. These assessments should consider the outcomes the person being assessed is hoping to achieve. They must also include the views of that person, either directly or via someone with authority to speak on their behalf. The regulator for health and social care in England, the Care Quality Commission (CQC, 2023), has since expanded the requirements of the Care Act. Regulation 9 stipulates that providers of care, including care homes, must ensure that the people they support are involved in the 'planning, management and review of their care'. Where the person supported lacks capacity, their wishes should be represented by someone acting on their behalf. This guidance further states that this broad mandate should include a 'clear' care plan with 'agreed goals'. Providers are also required to make sure that the care plan is available to all staff involved in the individual's care and that it includes an agreed review date.

Despite these requirements, very little research has explored care planning in older adult care homes (Taylor et al, 2023). Most research on care planning in older adult care homes has focused on two key areas. The first of these relates to advance care planning (Froggatt et al, 2009; Stone et al, 2013; Wickson-Griffiths et al, 2014; Owen and Steel, 2019; Spacey et al, 2020; Sussman et al, 2020). Advance care planning, which should be considered as part of the care-planning process (NHS England, 2016), looks at planning for the future, often focusing on end-of-life care. This contrasts with care planning more generally, which is concerned with understanding current needs and planning current care (DeVleminck et al, 2016). The second set of research has involved evaluating specific care-planning interventions, such as using a biographical approach to care planning (Brown Wilson et al, 2013), using quality-of-life tools to structure care plans (Towers et al, 2018) and using a case-conference model in care planning (Nakrem et al, 2019). While this literature has the potential to identify promising approaches towards care planning in the older adult care home sector, an understanding of current practice and issues is needed to inform attempts to improve how care planning is conducted. This study aims to address the gap in evidence and provide an understanding of how care planning is conducted in older adult care homes. The specific objectives of the study are:

- to identify the existing approaches to care planning in older adult care homes; and
- to understand the views of staff on care-planning practice in older adult care homes.

Methods

Study design and recruitment

The study purposively recruited social care professionals to take part in semi-structured interviews. The criterion for participation was professional involvement in conducting, managing or supporting the care-planning process for older adults

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living in a care home. The study sought to recruit between 20 and 25 social care professionals. Several recruitment methods were used, including drawing on existing contacts and via the National Institute for Health and Care Research (NIHR) applied research collaborations (ARCs), NIHR local clinical research networks (LCRNs), academic health science networks (AHSNs), Enabling Research in Care Homes (ENRICH) and the Contact, Help, Advice and Information Network (CHAIN). These methods were supplemented by recruitment calls on social media platforms, such as Facebook and X (formerly known as Twitter). This study followed the Standards for Reporting Qualitative Research (SRQR) reporting guidelines (O'Brien et al, 2014).[2]

Data collection

Semi-structured interviews (DeJonckheere and Vaughn, 2019) were conducted between September and December 2022 by six researchers (Hugh McLeod [HM], Jackie Damant [JD], Jonathan Taylor [JT], Laura Prato [LP], Nick Smith [NS] and Sarah Jasim [SJ]). Participants were offered a face-to-face or remote interview utilising MS Teams or Zoom. While the standard approach adopted was a one-to-one interview, in cases where more than one person was recruited from the same home, participants were offered a small group interview.

The interview topic guide drew on previous work on care planning (Towers et al, 2018) and a scoping review of care-planning interventions conducted by the project team (Taylor et al, 2023). The interview topic guide was used to enhance the comparability of the interviews. The topic guide included the following prompts: the aims of care planning; current care-planning processes; the use of care-planning data; challenges in conducting care planning; improving care planning; the potential of quality-of-life-based care planning; and implementing changes in care planning.[3] Interviews were audio-recorded and subsequently transcribed verbatim by a professional transcriber, with identifying information removed.

Analysis

Transcripts were analysed thematically, according to Braun and Clarke's (2006) six phases of analysis, using NVIVO (R1) and NVIVO Collaboration Cloud. Analysis was conducted by six researchers (JD, JT, LP, NS, SJ and Yuri Hamashima [YH]). In the first stage, researchers familiarised themselves with the transcripts. The second phase involved collaboratively creating an initial coding framework, using a deductive approach that drew on the interview schedule. In the third stage, the transcripts were coded according to this initial framework. During the fourth and fifth phases of the analysis, the project team reviewed the coding framework for coherence and credibility and revised where necessary. At this stage, coded material was used to inform the development of broad themes. The flexibility of thematic analysis allowed this later stage of analysis to switch from a 'top-down' deductive approach to a more inductive one that allowed themes to emerge from the data (Thomas, 2006). The sixth phase of the analysis consisted of selecting the most appropriate extracts and writing the findings section.

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Participants

A total of 22 social care professionals took part in the study; 19 of the interviews were conducted remotely, with three conducted in person. One interview was conducted jointly, with two participants interviewed together; others were one-to-one. As Table 1 shows, our sample primarily included participants who were female, white and aged between 45 and 54, and who had a leadership role within a care home. Most participants were based in homes that provided both older adult nursing and residential care (64 per cent), with a small number working in homes that provided just residential care (23 per cent) or just nursing care (14 per cent).

Table 1: Participant characteristics

		Activity staff (*n* = 1)	Health professional (*n* = 1)	Other leadership role (*n* = 12)	Registered manager (*n* = 3)	Registered nurse (*n* = 5)	Total (*n* = 22)
Gender	Female	100%	100%	67%	100%	100%	82%
	Male	0%	0%	33%	0%	0%	18%
Age	25–34	0%	0%	25.0%	0%	0%	14%
	35–44	0%	0%	25.0%	67%	20%	27%
	45–54	100%	100%	50%	33%	40%	50%
	55–64	0%	0%	0%	0%	40%	9%
Ethnicity	Asian/Asian British	0%	0%	8%	0%	0%	5%
	Black/Black British	0.%	0%	0%	0%	20%	5%
	Mixed/ multiple	0%	0%	8%	0%	0%	5%
	White	100%	100%	83%	100%	80%	86%

Patient, Carer and Public Involvement and Engagement statement

Two Patient, Carer and Public Involvement and Engagement (PCPIE) advisors were recruited to the project team. They contributed to the development and focus of the interviews and provided advice on engaging with the care homes, as well as comments and suggestions regarding the findings of the interviews and the final article.

Ethical statement

Ethical approval for this study was granted by the Staff Review Committee of the Division for the Study of Law, Society and Social Justice at the University of Kent on 19 July 2022 (Application Reference 692)

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Findings

Using thematic analysis, five distinct themes were developed: the aims of care planning; conducting care planning; support and resources for care planning; the use of care planning information; and improving care planning.

The aims of care planning

Participants suggested three main aims of care planning: assessing resident needs; providing person-centred care; and ensuring the provision of appropriate care. Participants described adopting a holistic approach to assessing residents' needs, which went beyond providing basic care. Ensuring appropriate care was identified as delivering care that was appropriate to the level of ability and independence maintained by the resident. Reference to the individual was often presented as being at the core of care planning:

> I think a good care plan should be individualised, shouldn't it? We're not all the same … we're all very, very different…. Like, what we like to eat, how we dress and, you know, our personality, so, yeah, I think every care plan should be– I very much reinforce that, it should be individualised. (Registered Nurse 1)

Person-centred approaches were described as requiring an understanding of the person, their life history, experiences and preferences. This included their preferences for aspects of personal care:

> If they prefer showers or baths, even down to what they like to use in their shampoo, their hair conditioner; if they like to go to the hairdressers. Do they like the staff to do it? Do they get washed in bed? Do they like to go to the bathroom? (Other Leadership Role 11)

Conducting care planning

The timing of care planning

Interviewees suggested that care planning occurred at three points in time: initial care planning conducted prior to or at the time that the person begins residence at the care home; care planning as part of ongoing regular review; and care planning in response to changes or incidents in a resident's life. Initial care plans were described as 'a very quick outline' (Other Leadership Role 2) and 'very condensed' (Registered Nurse 1). Other reflections suggested that there was not enough time at this stage for staff to get to know the resident or their preferences. A few participants also spoke of gathering information about new residents from other sources, such as hospitals, general practitioners (GPs) and social services. However, some interviewees distinguished between initial assessments, which were conducted prior to a person's arrival, and care planning, which started once a person had lived in the home for around four weeks.

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All participants spoke about conducting care planning at regularly scheduled intervals. Often, this regular ongoing care planning was based on the concept of a resident of the day. Usually organised monthly, on a specific day, one resident would receive a review of their needs through care planning and other activities. In a few interviews, participants also mentioned more extensive care-planning reviews. These were usually conducted on a six-monthly basis and, where possible, also involved family members. A third type of care planning occurred following an incident or event, such as a fall. In recognition that residents' needs can change rapidly, participants commented that care plans must be responsive to changing circumstances:

> If someone was to fall, they had a UTI [urinary tract infection], they went into hospital, that wouldn't wait a month to be updated on the care plan. That would be instantly put on that day, and when they come back from hospital, that care plan would be updated that day, if their mobility changed, if their eating and drinking changed. (Other Leadership Role 1)

The content of care planning

The content and focus of care planning were depicted as extensive and wide-ranging. Participants referred to care plans with multiple sections. Most participants mentioned topics that were synonymous with developing an understanding of the person, such as a person's life history and preferences: 'From day one, we start to document what the person likes to eat, what time the person likes to get up in the morning, how the person likes to sleep, whether with the lights on, or two pillows' (Registered Nurse 3). Other information collected included end-of-life preferences, assessments of risk, capacity assessments and health-related information, such as weight, respiration and medication. Several participants felt that some topics included in people's care plans, such as health-related aspects of residents' lives, reflected care providers' priorities rather than issues that were important to residents: 'The residents don't really care what their elimination plan says' (Registered Manager 1).

Digital care planning

Most of the participants worked in homes that had transitioned from paper-based care plans to digital platforms. The few participants working in homes that used paper-based systems almost uniformly noted that a move to a digital platform was imminent, partly due to limitations with a paper-based approach. Paper-based care plans were considered time-consuming to compile and update, physically cumbersome, and difficult to share with other professionals. This in turn created difficulties for staff to read and locate relevant information: 'I mean they're [care plans are] tomes … and it's impossible for people to sit and read them. They [care staff] don't know how to navigate through it, to get to the bit of information they need' (Other Leadership Role 2).

Participants who used digital care plans claimed that they were quicker to produce and easier to share with other staff members. As one participant explained, the main benefit was the ability to share care plans with staff in the home and with external care professionals: 'Everything is online, and all the carers walk around with a mobile device, and it's got all the information to hand there … everything they need to

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know about any patient is instantly available to them' (Other Leadership Role 1). Some participants also noted that the recording of care-planning information in a digital format widened the possibility for 'analytics' (Other Leadership Role 1). A few participants expressed reservations towards digital care plans. For example, some participants felt that digital systems could reduce care planning to a somewhat 'tick-box' exercise (Registered Nurse 04) that did not reflect a person-centred approach: 'This [digital care planning] is a process that I'm finding quite frustrating at this moment in time. I'm trying to be person centred and … the software is not allowing for it' (Registered Manager 2).

Involvement and partnership

Participants suggested that three main groups have a significant role in the care-planning process: care home residents; their family and friends; and care professionals. While a handful of participants suggested that the older adult care home sector did not directly involve residents in care planning, most talked about the importance of the care home resident in the care-planning process and how this was achieved in practice: 'We will try and sit down as much as possible if the resident has capacity, or if they have a capacity in certain areas, that we are able to sit and do the care plan with them' (Registered Manager 2). However, as the previous quote illustrates, resident participation in care planning is often contingent on mental capacity. Participants also suggested that residents were regularly excluded from end-of-life discussions because of concerns they might not understand the topic or may experience distress.

Residents' friends and relatives were identified as important contributors to the care-planning process, especially when a resident lacked capacity. Several participants offered a broad definition of family, going beyond next of kin and those with power of attorney to include close friends of the resident. Despite widespread agreement around the importance of involving family, some participants suggested that family contributions to care plans were not commonplace: 'It's unusual to do that [involve the family in care planning]…. I bet it would be less than 10 per cent actually have a conversation' (Registered Nurse 2).

Participants outlined several challenges associated with involving family members in care planning. Some questioned their reliability, suggesting that family members either do not want to admit 'how bad mum or dad may be getting' (Other Leadership Role 4) or exaggerate their relative's needs to secure care. Some participants noted that involving family members in care-planning conversations can be a time-consuming process, especially when family members are not able to come to the home in person.

Participants identified two broad groups of care professionals involved in the care-planning process: care home staff and external health and social care professionals. Within homes, participants stated that senior care or qualified nursing staff were usually responsible for conducting care planning. In some homes, while qualified or senior staff wrote the care plans, the information provided to populate them often originated from more junior staff within the home: 'Although it's a trained staff [member], they're qualified staff that will update the care plans, very much we take onboard what untrained staff are bringing to us' (Registered Nurse 1).

Other models of staff input were mentioned. For instance, one care home created a specific role of 'care plan coordinator' (Other Leadership Role 5) who had sole responsibility for all aspects of care planning. Another participant spoke about adopting

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an inclusive approach to involving staff in care planning: 'So, historically, it would have been the nurses writing the care plans. One of the things that we've been able to do … we have been able to delegate some of it, or at least updating some of the information' (Other Leadership Role 3). Several participants highlighted the contribution that external care professionals make to care planning. Most frequently mentioned were social workers: 'When I mentioned stakeholders [in care planning], this routinely is probably the social worker attached to the person. So, we contact them to say, "Have you got any updates?", "Is there anything that we need to know that we've not– we've not heard of?"' (Other Leadership Role 6). Healthcare professionals, including GPs, chiropodists and occupational therapists, also contributed to care plans. In some cases, involvement from external practitioners went beyond providing information and included writing parts of the care plan:

> We have a podiatrist that comes in every week, they will look through and they will write in it.... We have a GP round once a week … they will review residents that are poorly but also residents on their resident of the week; they will write on their sections in the care plan. (Other Leadership Role 7)

Support and resources for care planning

Time and staffing

A common issue raised by participants was the significant length of time required to complete the care-planning process due to the amount of information that needed to be collected. Participants expressed that time pressures were exacerbated by high workloads, staffing shortages and a lack of financial resources to adequately address them.

Others referred to the care sector's difficulty in recruiting and retaining staff and how this added to the challenge of conducting care planning effectively. Facing staff shortages, one participant stated that care homes prioritise direct care at the expense of care planning:

> Timing can be very difficult at times, particularly through the difficult times that we've been through in the last couple of years with COVID…. So, obviously, staff ratio is going to be very strained at those times. So, our priority is to deliver the hands-on care to the individuals at that point, and paperwork comes second. (Other Leadership Role 8)

Staff skills, experience and training

Staff skills, experience and training were discussed in a few interviews. Concerns were raised about staff lacking both confidence and experience in writing reports, holding discussions and making decisions, particularly with regard to end-of-life preferences. One participant noted that care assistants are sometimes expected to deal with complexities in care planning that, compared to nursing professionals, they were not qualified for.

Care-planning training was mentioned by a small number of participants. In most cases, the training for care planning was viewed negatively. Criticisms of training

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included that it was infrequent and 'haphazard' (Registered Nurse 5) and lacked continuity to ensure learning was embedded and sustained: 'I don't really know of a company that I've come across, yet, that actually trains people in how to do effective care planning' (Registered Manager 2).

Use of care-planning information

Informing care practice and improving quality of life

Most participants viewed care plans as a source of information to guide the care that residents received. Some participants provided examples of aggregating care-planning data to understand different aspects of care home life and potentially inform care practice:

> We can see, for instance, if [in] January you have 67 per cent of residents mobile and in December you had 70 per cent, so this difference, you track it, and, like, this you can make an estimate of, 'Okay, so what does that mean? Does it mean that our residents lost mobility through time, or does it mean that the residents that we admitted have less mobility?'. (Other Leadership Role 9)

Care plans were also used to provide staff with information about an individual's personal needs and preferences. For example, care plans could be used to encourage staff to accommodate a resident's fondness for animals or meet residents' food preferences:

> I found out the other day, just by chatting to one of the residents, that she doesn't like peas and the reason is because she feels they do something to her. And I go through her medical record, and they don't [record this] … she doesn't like peas, so now that's been put in [the care plan]. (Other Leadership Role 11)

Another participant explained that the care plan informed the care a resident received. This participant also noted that care plans could improve residents' experiences and quality of life: 'It [the care plan] was used as a guide … [to] how we can not just deliver their care but keep them happy, make it more of a home environment, involve their family and make it as close to being at home as it can for them' (Registered Nurse 5). A few participants suggested that care plans could also be used by external care professionals, such as GPs, occupational therapists and social workers, to inform practice and improve quality of care. Indeed, one participant suggested that care plans were not primarily for the care home staff because they knew all the information that the plan contained or shared it with each other. Instead, they were for external care professionals who might not know the resident or their needs and preferences.

Other uses of care-planning information

Participants also suggested that the information contained in care plans played a role in managing staff. This included using care plans to inform the supervision and training of staff and using aggregate data from digital care plans to inform staffing levels: 'One [way] in which we use the information is for dependency. So, it's important that we

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have our dependencies of our residents correct because that then decides on staffing levels that are required' (Other Leadership Role 4). Several participants felt that care plans were produced to ensure compliance with the CQC. This included compliance with risk registers and ensuring that the home passed audits and inspections: 'My view is that we are creating a lot of documentation around care planning and so on that people don't really need or use. It's there for audit purposes and it's there for CQC' (Other Leadership Role 3).

Improving care planning

The interviews also explored participants' views on how care planning and the processes surrounding it could be improved. In addition to the shift to digital care planning, participants presented several areas of care planning that they felt required improvement. These included improving staff training around care planning. One interviewee discussed the need to improve the accessibility of care-planning training: 'We're in a very mobile, quick, modern era now, where people want information very quick, very accessible…. If you can do training for ten minutes on the tube on your way into work, I don't need to have training for a full day at work' (Registered Nurse 5).

Some participants highlighted the absence of appropriate allocated time and resources to conduct care planning effectively. One participant suggested that having dedicated and protected time to conduct care planning might improve the quality of care plans: 'I think the only thing … that would help me – I would hope it would make care plans better – was if the senior staff, such as the nurse … were given supernumerary time to be able to concentrate on care plans' (Other Leadership Role 4).

Several staff suggested that care-planning information could be more efficiently collected by condensing the care-planning process. For some participants, this could be achieved by placing less emphasis on the health and risk-assessment aspects of care planning and focusing more on person-centred aspects: 'With an ex-war veteran who fought in the bloody, on the beaches on D-Day, he's going to go to the museum and be a volunteer because he loves children. That's his care plan; why's that not his care plan? That, to me, is an outstanding care plan' (Other Leadership Role 2). Others commented that more focus should be given to both advance care planning and planning for the end of life. Some participants suggested that staff found it difficult to discuss these issues and so avoided looking at topics related to the end of life when developing care plans. One participant suggested that care homes needed to raise the subject with residents and family members more often:

> It's hard sometimes having those [end-of-life] conversations with somebody that you've looked after for two years, but you have to acknowledge when the time's right….That means that you have to, as an organisation, have to … find a way to get it done on a proper risk-balanced basis, you know. Just don't say 'no' because it's inconvenient or it's too difficult. (Other Leadership Role 2)

Some participants mentioned the value of improving resident and family access to care plans, with one care home planning to give online access to residents and their families. However, most of the discussion around further accessibility was related to improving partnerships with other care providers by granting them greater access to

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digital care plans. Participants also spoke about enabling external care professionals to directly contribute to care plans. One participant suggested that to enable this partnership, care homes would need to adopt a standardised approach to care planning:

> I think the evolution of a care plan would be to have a standardised document that all health professionals, no matter where they're working, can access and read, that has the same format across the board, and I think as … an external healthcare professional, it'd be much easier to pick up a care plan with the same format as a care plan in another home. (Other Leadership Role 5)

The final improvement suggested was evidencing the impact of care and support from the care home. Several participants wanted to include quality-of-life measures in the care-planning process: 'It would be incredibly interesting and … much more valuable thing to be collecting for residents … demonstrating that somebody's quality of life is improving would be lovely' (Health Professional 1).

Discussion

This study has aimed to understand how care planning is conducted in older adult care homes and explore the views of staff involved in care planning. Findings have been organised around themes that reflected different aspects of care planning. These included the aims of care planning from the perspective of staff, how planning is supported and conducted, and how this information is used, culminating with material outlining how care staff would like to see care planning in this setting improved.

This study has some limitations. Our findings are based on a small self-selecting sample of social and healthcare professionals. Further to this, our sample was dominated by those with either a nursing qualification and/or a leadership role in the setting. Attempts were made to address this by using a range of different sampling methods. Interviewees were also encouraged to make their colleagues, including front-line care staff, aware of the opportunity to take part in the research project. However, our findings suggest that this sample accurately reflects the individuals currently conducting most care planning in older adult care homes. We are aware that the views of social and healthcare professionals represent only one perspective. Other stakeholders, particularly residents and their families and friends, may view care planning very differently from care staff. With this in mind, the research team involved in this work plans to conduct a series of focus groups to explore the experiences and perspectives of residents' families and friends. Nonetheless, by exploring how care planning is currently conducted in English care homes, this article addresses a gap in a field where most of the research focuses on interventions or advance care planning.

While our research was conducted in and reflects the specific context of older adult care homes in England, many of the issues raised resonate with care settings in other Western countries. For example, it was noted earlier that, as well as ideas around personalisation, the involvement of residents and families in care and care planning remains an important issue internationally, as do issues of funding and integrating health and social care.

The interviews suggest three different aims of care planning, with one of these being to improve person-centred care. Ideas of focusing on the person were also found in the other aims, suggesting that care staff view care planning as an activity

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that should reflect person-centred care. This is also found in discussions of how care planning can be improved, where participants spoke of ensuring that care planning focuses on the needs of the individual resident.

Care staff narratives concerning how care planning is conducted also reflected notions of involving the resident and person-centred care. Care planning was presented as an activity with a very broad focus, incorporating and recording information about many different areas of residents' lives. Understanding the resident, their history and their preferences emerged as a central concern of care planning. This sat alongside more standardised data collection, such as weight and blood pressure, which was presented as something to which the resident was subjected rather than something in which they were directly involved. This finding reflects earlier work (Kontos et al, 2010), which identified the use of medicalised and standardised approaches to care planning as key factors limiting person-centred care planning in older adult care homes. Our study found a similar picture in connection with resident involvement in the care-planning process. Every participant spoke about the importance of involving the resident in care planning, though this was often qualified by reference to either capacity or topic.

Residents thought to lack capacity were often excluded from the care-planning process, and even those who were judged to have capacity were shown to be excluded from discussing certain 'difficult' topics, such as end-of-life care preferences. Some participants suggested that when residents are not involved in care planning due to the absence of capacity or concerns about a difficult topic, family members would provide input to compensate and represent residents' perspectives. However, our findings suggest that this approach is often limited in practice. Indeed, some participants suggested that the care home sector did not routinely involve family members in the care-planning process, a finding not unique to this study. Other studies have found that family involvement in care planning is often limited (Worden and Challis, 2008; Ampe et al, 2016; McCreedy et al, 2018; Taylor et al, 2023). According to some participants, family perspectives may not necessarily reflect the views and experience of the care home resident, a finding that mirrors wider work on proxy responses to quality-of-life measures, where cognitive functioning is one factor (Hutchinson et al, 2022).

The findings also point to the care home sector's desire to involve external care professionals in the care-planning process and present limited examples of where this already happens. This was particularly identifiable during initial care planning, where homes often rely on information from social workers or from the hospital transfer to quickly understand and meet residents' needs. While later care planning and reactive revisions may happen once care home staff have gained a better understanding of residents' needs and preferences, there were examples of external care professionals, especially health professionals like GPs and chiropodists, being involved in ongoing care-planning processes. These findings show that some homes are adopting or want to adopt an integrated approach to the provision of care. Recent work exploring safety in older adult care homes has argued that residents' experiences in care homes are contingent on both what occurs within the home and the wider health and social care system (Smith et al, 2023).

Another key finding of our interviews was evidence of the transition towards digital-based care planning. Almost all participants were employed in care homes that used digital systems for care planning. Homes that still used paper-based care plans expected to adopt a digital platform in the near future. A recent review of studies of

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international care-planning interventions in older adult care homes (Taylor et al, 2023) found that just 11 per cent of the studies referred to digital care planning. The findings of this article suggest that there has been a rapid adoption of digital approaches to care planning in care homes in England and that the sector has responded to policy initiatives to increase the use of digital care records, such as the aim that 80 per cent of social care providers, including care homes, will be using digital care records by 2024 (Department of Health and Social Care, 2022). Study participants expressed broadly positive experiences of digital care planning and felt that, compared to paper-based care planning, the digital care-planning platform saved time and, as other studies have shown (Brittain, 2020; Kim et al, 2021; Ellis, 2022), may enable greater sharing of care-planning information with other parts of the care system.

Exploring how care planning is conducted in older adult care homes allows us to consider how the sector has adopted, interpreted and conceptualised key social care policy imperatives. Staff who conduct care planning appear to view notions of person-centred care, integrated care and digital transformation positively. However, while the adoption of digital technology in care planning was widespread among our study participants, our findings suggest that the implementation of person-centred care planning and care-planning approaches that reflect further integration of working practices between health and social care are more complex. The findings of this study suggest that these two aspects of care planning in older adult care homes warrant further investigation.

The findings also suggest that improvements in how care planning is conducted are required. This was recognised by our participants, who outlined a range of ways in which care planning in older adult care homes could be improved. One lens that has been applied to health and care settings to not only aid understanding and analysis but also support thinking around improvement is systems theory (Anderson, 2016; Jason and Bobak, 2022). At its core, system theory points to and highlights that any system is composed of interrelated and interdependent components and that the whole is greater than the sum of its parts (von Bertalanffy, 1969). Adopting a systems approach requires researchers to view a care home as both a system itself and, importantly, part of the wider complex ecosystem of health and social care. Understanding care homes as a system comprised of components that are interrelated leads to a recognition that components interact and impact one another. While the focus of care planning is the resident and their care, participants' calls for improvements reflect the interconnected nature of the components of the care home system. For example, the need to improve the skills and training of staff, both generally around care planning and more specifically around end-of-life care, illustrates how one component, the staff, may impact the resident. Recognising family members as a component of the care home system is also an important aspect of improving care planning. Enabling the involvement of family members in the care-planning process, especially where the residents may struggle to share their views and experiences, can help staff understand the residents and provide more personalised care.

Viewing care homes as part of a wider ecosystem can also support improvements in care planning. The most explicit example in our study was the importance placed on involving external care professionals in the care-planning process. The participants saw how residents were connected to wider systems of health and social care beyond the care home and acknowledged that these external components could impact the quality and effectiveness of care plans. By noting the connection to a wider ecosystem outside of the

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care home, the limits to what an individual care home can do to improve care planning are revealed. Participants spoke, for example, of the challenges around recruitment to the sector and the lack of resources and its impact on care planning. Another example that was evident in the study concerned the reluctance of care-planning staff to engage directly with residents about end-of-life care. While care homes can introduce mechanisms to support staff to do this more effectively, seeing the care home as part of a wider environment, where social expectations often mean that talking directly about death is avoided (Nelson et al, 2021), highlights the challenges of addressing this. These wider ecosystem factors suggest that to improve care planning in older adult care homes, challenges outside the direct control of care home managers may need to be addressed.

Conclusion

This study has aimed to understand how care planning is conducted in older adult care homes from the perspective of staff who are involved in the process. Despite significant desire from the sector, there is limited evidence to suggest that care planning is conducted in a person-centred way. There has been a rapid transition to digital care planning. There is a clear appetite for this practice to expand to include organisations that do not currently use digital approaches. This change has the potential to support data sharing with other care organisations and better integrate health services into care homes' practices. Participants also identified several barriers to improving care-planning practice. Our study suggests that care homes may lack the resources, including time and good-quality training, to improve how care planning is conducted in older adult care homes. Further work, which would benefit from adopting a systems approach, is needed to fully explore these barriers and facilitators in order to make the improvements that care staff believe could enhance residents' quality of life. This work needs to include the views of care home residents and their families.

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Notes

[1] Available at: www.legislation.gov.uk/ukpga/2014/23/contents/enacted.

[2] For more details, see Online Appendix 1, available at: https://arc-kss.nihr.ac.uk/document-download/677-smith-et-al-standards-for-reporting-qualitative-research-srqr/file.

[3] For more details, see Online Appendix 2, available at: https://arc-kss.nihr.ac.uk/document-download/678-smith-et-al-interview-topic-guide/file.

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Conflict of interest
The authors declare that there is no conflict of interest.

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