DEMENTIA

Dementia care plan: what goes in it and who writes it

What goes in a dementia care plan, who writes the NHS, council and home care plans, how often to review them, and a free checklist to use at home.

By the JNP Sidona team · 21 November 2026 · 11 min read

A dementia care plan is a written record of the support someone with dementia needs, how it will be given and what matters to them. Most families end up with more than one: the NHS says everyone should have a care plan after diagnosis, reviewed at least once a year; the council writes a care and support plan after a needs assessment; a home care provider writes its own plan for its carers; and an advance care plan records wishes for the future. A good plan is personal, specific and kept up to date.

KEY POINTS

- After a diagnosis, ask the GP or memory service for the care plan and the name of the person who coordinates care. The NHS says the plan should be reviewed at least once a year.
- If daily life is getting hard, ask the council for a free needs assessment. If your parent qualifies for help, the council writes a care and support plan, and the NHS says you should get a copy within a few weeks.
- Any CQC-registered home care provider has to plan care around the person's assessed needs and preferences, and involve them, or someone acting for them, in reviewing it.
- Begin with the person. The Alzheimer's Society's free "This is me" leaflet is a simple way to record life story, routines and preferences.
- Plan the future while your parent can still take part: Lasting Powers of Attorney, an advance statement and, if they want one, an advance decision to refuse treatment.

What is a dementia care plan?

It is a shared document that sets out what help a person with dementia needs, who gives it and how. The national guideline for dementia care, NICE NG97 (https://www.nice.org.uk/guidance/ng97/chapter/Recommendations), says each person should have a single named health or social care professional who coordinates their care. That person should develop a care and support plan, agree and review it with the person, their family and the professionals involved, say in the plan when it will be reviewed, and give a copy to the person and their family.

In practice, each service writes its own plan:

The main care plans for someone with dementia in England

Plan	Who writes it	What it is for	Review
NHS care plan after diagnosis	Usually the GP or memory service, with a named coordinator	Health needs, services that can help, and how to keep doing what matters	At least once a year (NHS)

Plan	Who writes it	What it is for	Review
Council care and support plan	Adult social care, after a needs assessment	The support the council agrees to arrange or fund, and how it will be given	Usually within the first few months, then yearly (NHS)
Home care provider's care plan	The care agency, after its own assessment	Day-to-day instructions for the carers who visit or live in	As needs change, and on a set date
Advance care plan	The person, with family and professionals	Wishes and decisions about future care and the end of life	At each care review (NICE)

The NHS care plan after diagnosis

The NHS says that "Following a diagnosis of dementia, you should have a care plan." (https://www.nhs.uk/conditions/dementia/care-and-support/help-and-support/) It should cover how the person can keep doing the things that are important to them, information about services and how to reach them, any health conditions that need regular monitoring, and the name of a health or social care person who will coordinate support. The NHS adds that the plan "should be reviewed at least once a year." If your parent never received one, ask the GP or memory service; our guide to the signs of dementia (/blog/signs-of-dementia) explains the diagnosis route in London.

The council's care and support plan

Anyone can ask their council for a needs assessment (https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/getting-a-needs-assessment/), and it is free. If the council decides your parent needs help, it writes a care and support plan. The NHS describes (https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/care-and-support-plans/) what goes in it: the type of support needed, how it will be given, what is important to the person, what they can do themselves and what their friends and family think. Reviews "usually happen within the first few months of support starting and then once every year." Our guide to the care needs assessment (/blog/care-needs-assessment) explains how to prepare.

The home care provider's care plan

An agency writes a more detailed plan for its own carers. CQC's Regulation 9 on person-centred care (https://www.cqc.org.uk/guidance-providers/regulations/regulation-9-person-centred-care) requires registered providers to base care on "an assessment of their needs and preferences", to work in partnership with the person, and to involve them, or someone lawfully acting for them, in "the planning, management and review" of their care.

The advance care plan

An advance care plan looks further ahead. Dementia UK (https://www.dementiauk.org/information-and-support/financial-and-legal-support/advance-care-planning/) describes it as "a record of your preferences about your future care and support", sometimes called an advance statement, and offers a free template. NICE says people with dementia should be offered "early and ongoing opportunities" to talk about Lasting Power of Attorney, an advance statement, advance decisions to refuse treatment, and where they would prefer to be cared for and to die. See also our guide to end of life care for dementia (/blog/dementia-end-of-life-care).

What goes into a good dementia care plan, section by section

A plan that only lists tasks gives a new carer little to work with. NICE suggests using a structured tool to record a person's "likes and dislikes, routines and personal history". These are the sections worth having, whoever writes the plan.

1. Life story and "This is me"

The Alzheimer's Society's "This is me" (https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me) is "a simple leaflet for anyone receiving professional care" who has dementia, delirium or other communication difficulties. It records cultural and family background, important life events, people and places, and preferences and routines. It works at home, in hospital, in respite or in a care home, and you can download it or order a free printed copy. Keep a copy with the care plan and take it to any hospital admission.

2. Daily routine

Write the shape of a good day: when they wake, how they like to get up, meals, favourite programmes, naps, and when they go to bed.

3. Communication

Note hearing aids and glasses (and where they are kept), first language, words they use for the toilet or for family members, and how they show pain, hunger or worry when they cannot say it.

4. Eating and drinking

Record likes, dislikes, cultural or religious food rules, texture advice and how to encourage drinks. NICE says to "encourage and support people living with dementia to eat and drink", and to consider a speech and language therapist if there are worries about swallowing safely.

5. Personal care

Bath or shower, time of day, what they can do themselves, the carer's gender, skin care and continence. Say what helps when a wash is refused.

6. Medication

List every medicine, who orders and collects them, and what the carer does: a reminder, or giving the tablets and recording them. Hiding medicines in food or drink is a separate legal process. NICE NG67 (https://www.nice.org.uk/guidance/ng67/chapter/Recommendations) says care workers must not do it unless there is clear authorisation and instructions in the provider's care plan, in line with the Mental Capacity Act 2005.

7. Mobility and falls

Walking aids, help with stairs and transfers, equipment, past falls and what to do after one.

8. Distress and what helps

Record what upsets your parent, such as noise or being rushed, and what calms them, such as a song or a walk. NICE says that before any treatment for distress, possible reasons should be explored and causes "for example pain, delirium or inappropriate care" checked for. The plan should prompt carers to think of pain, thirst or the toilet first.

9. Safety at home

Cooker, heaters, doors and keys, getting lost, scams, and who has the key safe code. Our guide to dementia care at home (/blog/dementia-care-at-home-guide) covers home safety in more detail.

10. Night-time

Usual sleep pattern, night-time toilet trips, lighting, and what happens if they wake confused. If nights are unsettled, the plan must say who covers them. Our guide to overnight care options (/blog/overnight-care-options) explains the difference between sleeping and waking cover.

11. Family and professional contacts

Next of kin, who to call first, who holds Lasting Power of Attorney, the GP surgery, pharmacy, memory service, social worker and district nurse.

12. Future wishes

Record whether there is a registered Lasting Power of Attorney, an advance statement or an advance decision, and where the documents are kept.

- **Lasting Power of Attorney (LPA):** GOV.UK says (https://www.gov.uk/power-of-attorney) there are 2 types, health and welfare, and property and financial affairs. The person must have mental capacity when they make one. Registering costs £92 for each LPA unless a reduction applies, and takes 8 to 10 weeks if there are no mistakes.
- **Advance statement:** the NHS says (https://www.nhs.uk/tests-and-treatments/end-of-life-care/planning-ahead/advance-statement/) it can cover "any aspect of your future health or social care", such as religious beliefs, where they would like to be cared for, or preferring a shower to a bath. It is not legally binding, but anyone making decisions about their care must take it into account.
- **Advance decision to refuse treatment (ADRT):** this is legally binding if it meets certain conditions. The NHS says (https://www.nhs.uk/tests-and-treatments/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/) the person must be 18 or over and have had capacity when they made it. To refuse life-sustaining treatment it must be written down, signed by the person and a witness, and include a statement that it applies "even if your life is at risk."

A dementia care plan checklist

Use this list to check a plan you have been given, or to draft one before an assessment.

About the person

- Preferred name, first language, faith and culture
- Life story, or a completed "This is me" leaflet
- Hearing aids, glasses and dentures, and where they are kept

The day

- Waking, meals, drinks, activities and bedtime
- Personal care preferences, including bath or shower and the carer's gender
- Food likes and dislikes, texture advice and help needed to eat
- Continence needs and toilet routine

- Walking aids, equipment and help with transfers

Health and medicines

- Diagnosis and other health conditions
- Full list of medicines, who orders them, and whether carers prompt or give them
- How the person shows pain
- Falls history and what to do after a fall

Wellbeing and safety

- What causes distress, and what helps
- Home safety risks and how they are managed
- Night-time pattern and who covers nights
- Key safe and access arrangements

People and plans

- Family contacts, and who to call first
- GP, pharmacy, memory service, social worker, district nurse
- LPA status and attorney details
- Advance statement and any advance decision, and where they are kept
- Preferred place of care in the future
- Date of the next review

Who should be involved?

The person with dementia comes first. NICE says to "encourage and enable" people with dementia to give their own views about their care, using other ways of communicating if needed.

Alongside them, involve the main family carer, any health and welfare attorney, the professionals involved (GP, memory service, social worker, district nurse) and the care provider once one is in place.

If your parent lacks capacity for a particular decision, it has to be made in their best interests under section 4 of the Mental Capacity Act 2005 (https://www.legislation.gov.uk/ukpga/2005/9/section/4),

which means considering their past and present wishes, any written statement they made, and the views of carers and any attorney. NICE says people should be told about local advocacy services, including an independent mental capacity advocate where appropriate. The person doing most of the caring can also ask the council for their own carer's assessment; see our carer's assessment guide (/blog/carers-assessment-guide).

How often should a dementia care plan be reviewed?

The NHS says the care plan after diagnosis should be reviewed at least once a year, and the council usually reviews its plan in the first few months and then yearly. NICE adds that the plan itself should say when and how often it will be reviewed, and that each review is a chance to look again at advance statements and decisions.

Dementia changes, so do not wait for the date. Ask for a review when:

- your parent has a fall, an infection or a hospital stay (see our hospital discharge checklist (/blog/hospital-discharge-checklist));
- medicines change;
- behaviour, sleep, eating or mobility changes;
- the family carer's own health or circumstances change.

Sudden change needs a doctor first. If someone with dementia becomes confused suddenly, over hours or a day or two, the NHS says (https://www.nhs.uk/symptoms/confusion/) to go to A&E or call 999. If the change is gradual, see the GP.

How a home care provider's care plan works in practice

Most agencies follow a similar pattern.

1. **An assessment at home.** Someone from the agency meets the person and the family, looks at the home and talks through the day. Bring the council's plan, the NHS plan and "This is me" if you have them.
2. **A written plan.** The agency writes its care plan, setting out the visits, what happens on each one, the risks and how they are managed. Correct anything that is wrong; it should sound like your parent.
3. **Carers follow it and record what they do.** Cover carers work from the same plan.

4 **Reviews.** The plan is updated as needs change, with the person and family involved, and usually on a set date too.

As dementia progresses, a care plan may move from a few visits a day to live-in care (/live-in-care-london), and later towards comfort and palliative care at home (/palliative-care-london). If the family carer needs a break, the same plan can be used for respite care (/respite-care-london).

Questions families ask

Is there a dementia care plan template?

Who is responsible for writing a dementia care plan?

Can the family see the care plan?

How we can help

JNP Sidona is a CQC-registered home care provider based on Lewisham High Street, and dementia is one of the specialisms listed on our registration. CQC has not yet inspected us, so we do not have a rating. Our carers help with personal care, meals, medicines and company; they are not nurses. Our dementia care at home (/dementia-care-london) starts with a free home assessment with Jackie, our registered manager, and we write a care plan with you after the assessment. If you have the NHS or council plan, or a completed "This is me", bring it along. Visiting care covers Lewisham, nearby south-east London and parts of central and east London, and live-in care is available across London.

Sources

1. NHS: Help and support for people with dementia (https://www.nhs.uk/conditions/dementia/care-and-support/help-and-support/), checked 21 November 2026
2. NHS: Care and support plans (https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/care-and-support-plans/), checked 21 November 2026
3. NHS: Getting a needs assessment (https://www.nhs.uk/social-care-and-support/help-from-social-services-and-charities/getting-a-needs-assessment/), checked 21 November 2026

4. NICE: Dementia: assessment, management and support for people living with dementia and their carers (NG97), recommendations (https://www.nice.org.uk/guidance/ng97/chapter/Recommendations), checked 21 November 2026
5. NICE: Managing medicines for adults receiving social care in the community (NG67), recommendations (https://www.nice.org.uk/guidance/ng67/chapter/Recommendations), checked 21 November 2026
6. CQC: Regulation 9, person-centred care (https://www.cqc.org.uk/guidance-providers/regulations/regulation-9-person-centred-care), checked 21 November 2026
7. Alzheimer's Society: This is me (https://www.alzheimers.org.uk/get-support/publications-factsheets/this-is-me), checked 21 November 2026
8. Dementia UK: Advance care planning (https://www.dementiauk.org/information-and-support/financial-and-legal-support/advance-care-planning/), checked 21 November 2026
9. NHS: Advance statement about your care wishes (https://www.nhs.uk/tests-and-treatments/end-of-life-care/planning-ahead/advance-statement/), checked 21 November 2026
10. NHS: Advance decision to refuse treatment (https://www.nhs.uk/tests-and-treatments/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/), checked 21 November 2026
11. GOV.UK: Make, register or end a lasting power of attorney (https://www.gov.uk/power-of-attorney), checked 21 November 2026
12. NHS: Confusion (https://www.nhs.uk/symptoms/confusion/), checked 21 November 2026
13. legislation.gov.uk: Mental Capacity Act 2005, section 4 (best interests) (https://www.legislation.gov.uk/ukpga/2005/9/section/4), checked 21 November 2026

About this guide

Written by the JNP Sidona team using the official sources listed above, which we checked on 21 November 2026. Rules, rates and thresholds change, usually each April, so always confirm the current position with the source or your council. This guide is general information, not medical, legal or financial advice. If you spot something out of date, email info@jnpsidonasupportservices.co.uk (mailto:info@jnpsidonasupportservices.co.uk) and we will correct it.