

Older Adult Care Planning and Documentation Training Course

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Course Overview

Older Adult Care Planning and Documentation Training Course is a one-week course for care coordinators, healthcare administrators, nursing supervisors, social care professionals, case managers, quality staff, and documentation leads who leave with an Older Adult Care Plan and Documentation Pack. Participants record needs, preferences, goals, risks, interventions, multidisciplinary contributions, progress, handovers, and reviews through one continuing case. The course strengthens continuity and accountability without teaching diagnosis or clinical procedures. Older adult care planning and documentation are taught by Agile Leaders Training Center.

Who Should Attend

- Care coordination functions responsible for assessments, plans, referrals, and follow-up
- Healthcare administration functions responsible for service records and continuity processes
- Nursing supervision functions responsible for documentation quality and team handovers
- Social care functions responsible for preferences, daily support, and family involvement
- Case management functions responsible for goals, interventions, reviews, and transitions
- Quality functions responsible for record audits, corrective actions, and care-plan assurance

The course assumes participants already support older adults, care teams, or service records, and it leaves out diagnosis, prescribing, treatment decisions, and clinical procedures.

Departments and Industries

The course supports coordinated care records across health, social-care, residential, and community settings.

- Healthcare administration, care coordination, and quality
- Primary care, community services, and home-care operations
- Residential care, assisted living, and day services
- Social services, case management, and family support
- Rehabilitation, allied health, and transition coordination
- Nonprofit and public-service organizations supporting older adults

Learning Objectives

By the end of this course, participants will be able to:

- Analyze needs, preferences, strengths, risks, and support networks
- Build person-centered goals, interventions, and responsibility records
- Apply consent, capacity, safeguarding, and escalation documentation
- Use progress notes, handovers, and multidisciplinary contributions
- Evaluate review triggers and update care plans
- Build documentation audits and corrective action records

Course Agenda

Day 1: Person-Centered Care Information

- Older Adult Profile and Preference Record
- Strengths, Needs, and Support Network Map
- Functional Ability and Daily Routine Profile
- Communication and Accessible Information Record
- Care Planning Involvement Map

Day 2: Goals and Care Plan Design

- Priority and Outcome Definition Sheet
- Person-Centered Goal Statement Method
- Intervention and Support Action Table
- Responsibility and Coordination Matrix
- Care Plan Agreement and Version Record

Day 3: Risk, Consent, and Safeguarding Records

- Risk and Protective Factor Register
- Consent and Decision Participation Record
- Capacity Concern and Referral Note
- Safeguarding Observation and Escalation Log
- Confidentiality and Information-Sharing Checklist

Day 4: Progress, Handover, and Review

- Objective Progress Note Structure
- Multidisciplinary Contribution Template
- Care Handover and Transition Record
- Review Trigger and Change Detection Matrix
- Care Plan Update and Closure Log

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Day 5: Documentation Practice and Capstone

- Needs and Preferences Recording Exercise
- Goal and Intervention Design Exercise
- Risk and Safeguarding Documentation Exercise
- Progress Note and Care Review Exercise
- Capstone Older Adult Care Plan and Documentation Pack

Practical Exercises

The course uses suggested activities that connect person-centered information, coordinated action, daily records, and review decisions.

- Suggested activity: build a preference and support profile for an older adult receiving home care
- Suggested activity: convert agreed priorities into goals, interventions, owners, and review points
- Suggested activity: document a safeguarding concern and route it through the defined escalation process
- Suggested activity: audit progress notes and update a residential care plan after a change

FAQs

Who is the Older Adult Care Planning and Documentation Training Course suited to?

The course suits intermediate care, administration, coordination, supervision, social-care, case-management, quality, and records professionals who already support older adults or their service documentation.

How does older adult care planning and documentation differ from clinical geriatric training?

Older adult care planning and documentation focus on person-centered goals, coordinated support, records, handovers, reviews, and quality controls, while clinical geriatric training addresses diagnosis, prescribing, treatment, and clinical procedures.

What should an older adult care plan document?

An older adult care plan should document preferences, strengths, needs, desired outcomes, agreed goals, support actions, responsibilities, risks, consent and involvement, communication needs, review points, and changes.

How should progress notes support an older adult care plan?

Progress notes should record relevant observations, actions, responses, changes, communications, and follow-up in objective language linked to the person's goals and current plan.

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When should an older adult care plan be reviewed?

An older adult care plan should be reviewed at agreed intervals and when needs, preferences, functional ability, risks, support arrangements, transitions, incidents, or outcomes materially change.

Conclusion

Participants take back an Older Adult Care Plan and Documentation Pack containing profiles, goals, interventions, responsibilities, risk records, consent notes, progress entries, handovers, reviews, updates, and audit tools. The pack creates a shared record for older adults, families, and care teams. It helps services preserve preferences, coordinate support, identify changes, and improve documentation quality.

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