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ABSTRACT

Background Person-centred care planning is essential in mental health inpatient services, ensuring that patient goals align with clinical recovery plans. Despite its recognised importance, occupational therapists (OTs) in acute inpatient settings often face challenges in implementing structured, person-centred care plans within 10 days of admission based on the OT process within the acute inpatient services. The Goal-Directed Care Planning (GDCP) framework, previously successful in forensic and rehabilitation settings, was introduced to improve OT input into care plans in acute inpatient services.

Objective This study aimed to enhance the person-centredness of occupational therapy care plans by implementing the GDCP framework, with a target of improving OT contributions from 27.44% to 70% by October 2024.

Methods A quality improvement approach using multiple plan-do-study-act cycles was employed to embed the GDCP framework into three inpatient wards. Key interventions included standardising OT care-plan input, providing in-house training on care-plan audits, and ensuring timely documentation of patient goals and interventions. Monthly audits were conducted to assess progress and identify areas for further improvement.

Results Across the board, OT input into care plans significantly improved from 27.44% (June–October 2023) to 53.25% (November 2023–October 2024). Ward-specific improvements were observed, with Ward T increasing from 24.42% to 43.32%, Ward M from 37% to 67.03% and Ward P from 21.09% to 44.34%. Key areas of improvement included clearer goal-action links and increased involvement of patients in care planning.

Conclusion Implementing the GDCP framework enhanced the quality and consistency of OT contributions to care plans, fostering a more structured and outcome-driven approach. However, ongoing challenges such as workforce shortages and OTs being allocated to non-specialist roles in safer staffing need to be addressed to sustain improvements in person-centred care planning.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ A previous paper successfully used codesigning and Goal-Directed Care Planning (GDCP) principles to improve the person-centredness of occupational therapy input into care plans in a forensic and rehabilitation setting.

WHAT THIS STUDY ADDS

⇒ Our paper provides a clear and replicable account of how we used the learnings from the previous project to improve the person-centredness of occupational therapy input into care plans in an acute adult and older adult inpatient mental health service.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study highlights the importance of structured, goal-directed care planning in mental health inpatient settings, demonstrating that implementing the GDCP framework can significantly enhance occupational therapy contributions to person-centred care. Its findings may inform policy changes to prioritise occupational therapists' specialised roles, ensuring they are not diverted to non-specialist tasks, and guide future research on sustaining care-planning improvements despite workforce challenges.

PROBLEM

Person-centred care is an approach that prioritises the individual within their broader context, rather than focusing solely on bodily systems or diseases.[1] It emphasises respect for personal diversity, promotes transparency and ensures system accountability, empowering individuals to take an active role in their healthcare. Personalised care planning unites personal recovery goals with clinical recovery by collaborating with patients and their carers/families, involving them in their care and treatment interventions.[2] This approach positively impacts patients' health outcomes, aids their transition from inpatient to community mental healthcare and reduces non-adherence to interventions and relapse.[3 4]

Despite understanding the importance of person-centred care planning, various organisational factors such as limited patient therapeutic contact time and lack of training on an evidence-based framework for person-centred care planning hindered occupational therapists (OTs) from creating person-centred care plans within 10 days of admission based on the local organisational OT process in the acute adult inpatient service. An audit conducted using the Goal-Directed Care Planning (GDCP) audit tool indicated that quality of person-centred care planning was 27.44% from June 2023 to October 2023.

During care planning, patients identify broad goals such as returning home, resuming work or achieving independence. However, these goals are often generic and lack clear structure, making it challenging to align them with the specific, measurable, achievable, relevant and time-bound (SMART) framework. This lack of clarity can hinder effective intervention planning, goal tracking and overall patient progress. Even when such goals are written in a SMART format, they often lack details on how to achieve them.[5] Such goals typically require multidisciplinary team (MDT) interventions that are safe, effective and person-centred. These challenges mirror findings from a recent systematic review, which revealed the absence of a standardised approach to goal planning across mental health services.[6] Instead, practices varied significantly depending on practitioner training, service models and individual client needs. This inconsistency further complicates efforts to implement goal-oriented care and underscores the need for more structured, collaborative and recovery-focused goal planning in mental health settings.

The GDCP framework[7] ensures care is driven by patient goals through collaborative assessment, intervention and evaluation. It enhances engagement, improves outcomes and keeps interventions focused and measurable. Adopting lessons from a recent quality improvement (QI) project led by OTs from our forensic and rehabilitation services,[8] goal achievement was linked to actions to patient goals, ensuring time-bound interventions and fostering collaboration. We also found that clear review dates and staff accountability improved coordination, helping patients quantify broad goals like independence and recovery. It also promoted person-centred care through better communication and patient/carer involvement. With the team working together, the OT team developed a QI project to use the GDCP principles to improve the person-centredness of OT input into care plans from 27.44% to 70% by October 2024. The agreement on the target of 70% was based on factors perceived by the OTs which were unique to acute mental health inpatient services such as sickness, vacancies and increasing acuity of patient needs.

BACKGROUND

Care planning involves collaboration between a health practitioner and a patient to identify and agree on a goal to be achieved over a defined period.[9] The SMART framework originated from management culture and has been widely adopted in various fields, including mental healthcare, as a popular tool for goal setting.[10–13]

Nonetheless, there are significant limitations in using the SMART goal format within mental healthcare. Initially, the first publication about the underpinnings of SMART goals was neither based on any theoretical framework nor a critical analysis of literature.[10 11] Instead, it was based on the professional opinion of a management consultant aimed at a business audience,[10] indicating a challenge of transferability of this method of goal setting in acute mental health settings without clear guidance.[14]

Patients with severe mental illness often have diverse needs that may not be fully addressed by traditional goal-setting approaches.[15] For instance, it can be challenging to quantify a patient's goal to stop hallucinating (hearing voices) in a SMART format due to the multidisciplinary and multifaceted interventions required. Allied health practitioners (AHPs) have also experienced challenges articulating patient goals within specific and measurable statements.[16] Another limitation of research evidence on SMART goals within acute mental health settings is that they do not factor in the implementation process or assign accountability for interventions. This makes it challenging to ensure consistent follow-through on interventions, potentially impacting patients' personal recovery and care outcomes.[17 18]

A more suitable approach to goal setting in mental healthcare is the GDCP framework, which provides step-by-step guidance for SMART goal setting to ensure structured, measurable and patient-centred progress.[7] Breaking down goals into action plans is particularly important as it reduces patient uncertainties about effectiveness and alleviates fears about the coerciveness of interventions.[19] GDCP specifies where, when and how a goal should be implemented, helping patients plan specific actions to achieve their overarching goals.[7 17 18] This ensures transparency and predictability of treatment, making patients feel safe, valued and motivated to adhere to treatment plans.[20–22]

GDCP is particularly vital to achieving goals in acute mental health inpatient units due to characteristics such as being conceived by the patient (person-centredness), shared with others (involvement of the triangle of care) and short duration (eg, 1 week duration with weekly re-evaluation). This approach encourages timely and person-centred care in line with the NHS long-term plan.[23]

This project was designed to support OTs working within an acute inpatient service by aiding their patients in care planning to achieve overarching goals using action/intervention planning as proposed by the GDCP.

MEASUREMENT

How the information was acquired

Baseline data for the adult acute inpatient unit were collected using the GDCP audit tool, encompassing three distinct wards within the unit. Ward M is a 20-bed facility dedicated to the care of women. Ward P also comprises 20

beds and serves a mixed-age population, primarily adults aged 18 and over, with 12 beds specifically allocated for older adults aged 65 and above. Ward T is a 20-bed ward designated for men.

Each month, from June to October 2023, five care plans of newly admitted patients per ward were audited. In cases where fewer than five new admissions occurred, all available care plans for newly admitted patients were reviewed. In acute inpatient mental health, OTs must complete care-plan input within 10 days of admission, compared with 28 days in forensic and rehabilitation services. The baseline measurement of the person-centredness of care plans was 27.44% for the service from June to October 2023 (online supplemental figure 1). The team agreed to improve the person-centredness of their care planning to 70% by October 2024.

DESIGN

A collaborative session was facilitated by the project lead alongside the OT team, which included one lead OT, three senior OTs and six OTs. The session aimed to identify challenges and develop solutions to enhance the person-centred approach to care planning. The baseline measurements were presented to the team, providing an opportunity for open discussion. Team members brainstormed the underlying causes of the identified challenges and proposed potential change ideas to address them effectively. A driver diagram was used to identify the proposed change ideas (online supplemental figure 2). A driver diagram is a structured tool used in improvement projects to show how a specific aim can be achieved. It outlines the overall aim, identifies primary drivers and breaks these down into secondary drivers, which are more specific components. For each secondary driver, the diagram includes change ideas (practical actions that can be tested to drive improvement). This approach helps teams focus efforts, track progress and implement changes systematically.[24] The team established 1-hour monthly meetings to discuss the implementation of tests of change and work in collaboration to find solutions to any challenges faced during the project. Key insights from the QI project in the forensic and rehabilitation services were applied by the project team, including alternating team meetings between face-to-face and online formats to enhance interaction while reducing our carbon footprint. Additional measures included the early training of senior and lead OTs to audit care planning, mitigating reliance on the project lead as the sole point of accountability. Furthermore, standardising OT care plans improved consistency and maximised the efficiency of OT contributions to patient care.[8] Pareto charts were used to identify key areas of the care plan audit that required the most attention as part of the improvement project (see online supplemental figures 3–5). However, the OT team ultimately decided to focus on enhancing all care-plan criteria identified by the GDCP audit. This decision was made because none of the criteria of the audit had been fully optimised by OTs in their contributions to care plans.

STRATEGY

Change idea 1: standardising OT care-plan input into system 1 care-plan template

PDSA cycle 1 (November 2023)

Plan

Underpinned by the SMART framework, the project team decided to use the example of a care plan standardised by using the GDCP audit tool criteria from a concluded QI) project in the forensic and rehabilitation services. Both services used a similar system 1 electronic health record template, making this a relevant starting point.

Do

Standardised examples of care-plan input were introduced to the whole OT team and reviewed by a mental health inpatient expert by experience (MHEBE). The participation of the MHEBE in informal consultations offered important perspectives, especially on the accessibility of care plan information, which contributed to refining and improving the overall care-planning process. Recognising the unique needs of older adults on Ward P, a separate standardised example was specifically developed for this ward (online supplemental figures 6 and 7).

To ensure these care plans were appropriate and person-centred, the OT team and the MHEBE reflected on the standardised examples. They provided valuable insights and feedback through informal discussions, helping to refine and enhance the care-planning process. These were then presented to the clinical reference group for further review and recommendations. Additionally, the clinical lead shared these findings at a local operational meeting to engage operational managers, ensuring their input and promoting the long-term sustainability of the project.

Study

Feedback from the MHEBE and the OT team was positive, particularly highlighting the clarity and person-centred nature of the care-plan examples. It also aided them to be able to input into care plans efficiently. The expert by experience noted the simplicity and brevity of the care plan, while clinical leaders and senior managers also expressed satisfaction with its content.

Act

The project lead presented the care-plan template to the entire OT team, allowing them to ask questions and gain clarity. The team agreed to use the standardised examples as a reference for completing future goal-directed care plans. They also committed to undergoing training to consolidate their understanding of care planning.

Change idea 2: in-house training for OTs to reduce costs

PDSA 1 (November 2023)

Plan

To aid sustainability of the project, the OT team agreed to train one senior OT and the lead OT on how to complete care-plan audits. This approach was inspired by previous learnings from the QI project in the forensic and rehabilitation services. The primary goal was to reduce reliance

on external trainers and ensure cost-effectiveness by developing in-house expertise.

Do

The project lead conducted training sessions with the senior OT and the lead OT, teaching them how to use the GDCP audit tool. Instructions were standardised, outlining where to find relevant information in the patient records and how to audit OT input into the care plans. The following audit guidelines were established:

- Five newly admitted patient care plans per ward were to be audited monthly.
- Audits for a given month would be completed by the second Monday of the following month (eg, the March 2024 audit would be completed by Monday, 8 April 2024).
- Completed audits would be sent to the project lead for quality checks.
- Areas of improvement identified by the audit will be resolved within 7 days of the completion of the audit.

Study

The audit results for November 2023 were as follows: Ward T scored 47.27%, Ward M scored 49.09% and Ward P scored 60.61%, resulting in an average score of 52.32%. This was an improvement of 12.32% compared with October 2023.

However, audit scores decreased in the following months, with the average dropping to 38.88% in December 2023 and 38.94% in January 2024. The decrease was attributed to staff sickness in Ward T and Ward P.

Act

The senior and lead OT agreed to continue conducting monthly audits and to discuss the results during team meetings. To address the decline in audit scores, the OTs agreed to participate in further training, which would focus on how to input care plans into system 1 platform and the rationale behind the auditing process.

PDSA 2 (February 2024)

Plan

Training all OTs in the care-plan audit criteria and rationale.

Do

The project lead met all OTs to discuss how the audit was scored. This included how to develop the care plan efficiently, such as inputting agreed goals from initial screenings immediately into care plans and detailing the interventions agreed to achieve the goal.

Study

The average audit score for the three wards increased to 51.52% in February but decreased to 44.85% in March 2024. The reduction was attributed to the sickness of the senior OT on Ward T resulting in a low score of 18.18% for March 2024.

Act

The OT team determined that it was essential to provide training for the two remaining senior OTs in conducting audits based on the GDCP framework. This initiative aimed to enhance their professional competencies while distributing the responsibility of auditing, thereby supporting the long-term sustainability of the project.

PDSA 3 (April 2024)

Plan

In April 2024, the project lead initiated a hybrid training session with the remaining two senior OTs alongside the senior and lead OTs that were already trained. The goal was to train them on using the care-plan audit tool and to incorporate key learnings from a recent Care Quality Commission (CQC) visit. The training emphasised how patient risk assessments and safety planning should be reflected in the care plans.

Do

During the session, the project lead provided detailed guidance on how to use the audit tool alongside the care-plan template. Instructions were given on where to locate specific information in the care plans, which was also added to the template. Additionally, lessons from the CQC visit were incorporated, particularly around ensuring that risk assessments and safety planning were well documented in care plans. For instance, OTs were instructed to include risk mitigation strategies in the 'What needs to happen' section of the intervention plan. An example was given where an OT, preparing a meal assessment for a patient with a history of self-harm, should note safety precautions such as cutting ingredients in advance and securing sharp objects.

Key actions agreed on included:

1. Learning from risk assessments and safety planning would be incorporated under the 'What needs to happen' section of the intervention plan (see online supplemental figure 6). For example, when planning an activity like meal preparation for a patient with a risk of self-harm, the OT could outline how the risk would be mitigated (eg, pre-cut ingredients, securing sharp objects).
2. The care-plan audit would be submitted to the project lead by the second Monday of each month, with the lead OT copied. A reminder for this was set in the project lead's Outlook calendar.
3. The senior, already experienced with the audit process, would complete the April 2024 audit alongside the newly trained OTs, providing feedback and quality checks.
4. The two newly trained senior OTs would officially start their audits in May 2024, with the results due by the second Monday of June.

Study

The audit results for April 2024 were:

- Ward T: 60%.

- Ward M: 41.82%.
- Ward P: 70.91%.

The average audit score across the three wards was 57.58%, a 13% improvement from March's results. However, the area where OTs faced the most difficulty was 'The date/timeframe within which each action will be completed.' This section of the action plan consistently showed low scores across all wards, with an average of 25.18% since November 2023. The team identified that new recruits were struggling with the action planning portion of the care plans, likely due to their unfamiliarity with the patient's record template and process. Other areas of difficulty included:

- Clarifying which actions correspond to each goal.
- Identifying the person responsible for implementing each action.
- Specifying who would receive the care plan.

These challenges were linked to the intervention/action planning portion of the care-plan template.

Act

To address the challenges identified, a senior OT volunteered to develop an induction document specifically for newly recruited OTs. This induction plan includes a detailed step-by-step guide for new staff on completing care plans effectively.

The template emphasises:

- Setting clear timeframes for interventions.
- Assigning a designated person responsible for each action.

This initiative aims to enhance the action-planning component of care plans and ensure all OTs, including new recruits, have a thorough understanding of how to use system 1 care-plan templates efficiently.

PDSA 4: induction plan for care plans (May 2024)

Plan

Create induction document to support OT input to care plans on system 1.

Do

The induction document was created (see online supplemental figure 8) and given to all the newly recruited OTs.

Study

The audit results for May 2024 were:

- Ward T: 45.45%.
- Ward M: 74.55%.
- Ward P: 68.18%.

The recent audit revealed an increase in average person-centredness scores across all units, reaching 62.73%. The audit scores increased to 67.88% in June but reduced to 50.30% in July.

However, several areas for improvement were identified across the three wards:

1. Timeframes for treatment actions: OTs often struggled to specify the date or timeframe for completing treatment actions.
2. Care plan completion: care plans were not consistently completed within 10 days of patient admission.
3. Time constraints: OTs reported an increase in being assigned to within-observations tasks, which limited their time for care planning and therapeutic patient engagement.

Act

- Support for new graduate OTs: senior OTs provided targeted support to their Band 5 colleagues, addressing the identified improvement areas within 7 days of the audit.
- Change idea proposal: the OT team proposed a change idea and discussed redefining how OTs are used on the wards. This initiative aims to provide managers with clear guidance on balancing emergency support needs with the therapeutic priorities of patient care.

Change idea 3: review how OTs are used for patient observations on the wards

PDSA1 (September 2024)

Plan

Create a guidance for Ward managers on how ward-based OTs are used for patient observation.

Do

This guidance was sent to the area service manager (ASM) for the unit and the lead OT was tasked with discussing this in the operations meeting with ward managers (online supplemental figure 9).

Study

The ASM of the hospital unit discussed this with the ward managers. This was also discussed within the operational meeting. The audit scores reduced by 43.89% in August but increased to 58.18% in September and 71.91% in October 2024.

1. Timely completion of care plans: after initial assessments, OTs should complete care plans immediately, including their name, goals from the assessment and proposed interventions. This process takes about 15 min but significantly enhances care-plan quality.
2. Engaging with patients unable to participate: for patients who cannot engage in care planning, OTs should consult family members, carers and the community team, following the *Triangle of Care* model.[25] Gather relevant information (eg, accommodation status, self-care abilities such as shopping or meal preparation) while maintaining strict confidentiality.
3. Specifying dates and timeframes for actions: interventions should include clear, actionable timeframes. For example: 'OT Joshua will organise a weekly shopping trip to Tesco to assess budgeting skills.'
4. Recording key contributors in care plans: recording the full name and role of the OT and support network (family and carers) in the following areas to ensure that they are explicitly identified.
   - In Section 3 of the adult care plan: 'Who do I want involved?'

- In Section 4 of the older adult care plan: 'Who else could help you achieve your goals or live well, and what can they do?'

Act

- Support for new graduate OTs: senior OTs provided targeted support to their junior colleagues, addressing the identified improvement areas within 7 days of the audit.
- Monitoring the impact of the guide on OTs for patient observations on the timeliness and their ability to engage patients in person-centred care plans.

RESULTS

Person-centred occupational therapy input into care plans significantly improved from 27.44% (June–October 2023) to 53.25% (November 2023–October 2024) (online supplemental figures 10–18). The improvements across individual wards were as follows:

- Ward T: increased from 24.42% to 43.32%.
- Ward M: increased from 37% to 67.03%.
- Ward P: increased from 21.09% to 44.34%.

Highest scoring areas

For each ward, the most improved aspects of the GDCP audit were:

- Ward T:
  - People involved in care-plan development: 30.67% → 53.33%.
  - Patient's current context: 44% → 53.33%.
- Ward P:
  - Clear format linking actions to goals: 26% → 62.50%.
  - People involved in care-plan development: 26% → 60.69%.
- Ward M:
  - Client's current context/current situation: 57% → 85%.
  - Clear format linking actions to goals: 20% → 78.33%.

Lowest scoring areas

Despite improvements, some areas still require further attention:

- Ward T:
  - Completion of the care plan within 10 days of admission: 14.67% → 31.67%.
  - Timeframe for action completion: 0% → 15%.
- Ward P:
  - Timeframe for action completion: 13% → 14.31%.
  - Clarification of who will receive the care plan: 17% → 37.08%.
- Ward M:
  - Timeframe for action completion: 16% → 40%.
  - Setting a review date for the care plan: 16% → 53.33%.

These results highlight significant progress while also identifying areas for continued improvement, particularly in ensuring timely completion and clear timelines for action within care plans.

DISCUSSION

This study contributes to the growing body of literature advocating for structured frameworks to enhance person-centred care planning in mental health services. Building on the success of the GDCP framework in forensic and rehabilitation settings,[8] our findings demonstrate its adaptability and effectiveness in acute adult and older adult inpatient contexts. These settings are uniquely characterised by shorter admission durations, higher patient acuity and operational pressures that often hinder therapeutic engagement.

The improvement in person-centred OT input—from 27.44% to 53.25%—is particularly noteworthy given these constraints. While the target of 70% was not fully achieved, the gains are comparable to those observed in less pressured environments, such as our forensic and rehabilitation services.[8]

Implications for practice and policy

The results underscore the importance of embedding structured goal-setting frameworks like GDCP into routine OT practice. Improvements in goal-action linkage, patient involvement and contextual relevance suggest that GDCP not only enhances documentation quality but also facilitates therapeutic engagement. The involvement of an MHEBE in developing standardised care-plan templates further reinforced the person-centred ethos of the project.

From a policy perspective, the findings highlight the need to safeguard specialist OT roles from dilution through redeployment. The frequent assignment of OTs to observation duties under safer staffing protocols—intended to ensure adequate numbers of appropriately skilled healthcare professionals are available to deliver safe, high-quality care[26]—undermines their capacity to deliver therapeutic interventions, including care planning. This tension between safety management and recovery-focused care must be addressed through clearer operational guidance and staffing models that prioritise clinical expertise.

Additionally, the study demonstrates the feasibility of using in-house training and induction resources to build capacity and sustain improvements. By decentralising audit responsibilities and equipping senior OTs with the skills to support their teams, the project fostered a culture of shared accountability and continuous learning, an approach particularly relevant in resource-constrained environments.

Lessons learned

Several key lessons emerged from the project:

- Standardisation enhances clarity and efficiency: the use of standardised care-plan templates improved consistency and enabled staff to align goals with interventions more effectively.
- Training and induction are critical: new recruits struggled with action planning and timeframes,

highlighting the importance of structured onboarding and ongoing support.
- Collaborative leadership drives change: involving senior OTs in audit and training activities promoted ownership and sustainability, reducing reliance on the project lead.
- Operational pressures must be managed: redeployment of OTs to non-specialist roles remains a significant barrier to person-centred care and requires strategic oversight.

Strengths and limitations

Despite significant improvements, the outcomes remained below those achieved in our forensic and rehabilitation services.[8] However, the 25.81% improvement observed in this study is comparable to the gains reported in those settings and was achieved under more challenging conditions including shorter care-planning timeframes, staff vacancies and high turnover.

Care planning in mental health has often been criticised as bureaucratic and detached from genuine patient engagement.[27] This project addressed these concerns by implementing GDCP, ensuring care plans reflected patient needs through SMART goal setting. The initiative also fostered innovation and evidence-based practice, strengthening interdisciplinary collaboration and professional development.

Nevertheless, the ongoing redeployment of OTs into safer staffing roles continues to disrupt the delivery of specialised interventions. Extended periods of patient observation often result in the cancellation of therapeutic sessions, delaying recovery and increasing reliance on risk containment strategies.[28] Addressing this issue is essential to sustaining high-quality, person-centred care.

RECOMMENDATIONS AND CONCLUSION

Future research should explore the long-term impact of GDCP implementation on patient outcomes, including recovery trajectories, engagement levels and satisfaction. Developing AHP-specific patient-reported outcome measures would provide valuable insights into the effectiveness of OT interventions and support evidence-based staffing decisions.

There is also a need to evaluate the impact of safer staffing frameworks on the quantity and quality of OT interventions such as assessments, care planning and treatment. A longitudinal study examining how redeployment affects care planning, assessments and therapeutic interventions could inform policy changes aimed at preserving specialist roles. Finally, expanding the GDCP framework to other disciplines within the MDT may enhance the overall care-plan quality and foster a more integrated approach to recovery-focused care.

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Contributors JJIl led and wrote up this study. This included leading the clinical team to carry out the PDSA cycles and the collaboration involved. ES developed the step-by-step guide for new starters to input into care plans on system 1. EJ and ES supported with auditing OT input into care plans and participated in the training of band 6 occupational therapists to complete the audits. OB and DM critically reviewed the manuscript, refining core arguments, leveraging on clinical and academic mental health nursing expertise. JJIl as the guarantor of this study accepts full responsibility for the finished work and the conduct of the study, had access to the data, and controlled the decision to publish. AI was used to improve sentence conciseness, correct grammatical errors and ensure the study adhered to the word limit.

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Patient and public involvement A mental health inpatient expert by lived experience contributed to the development of a standardised, person-centred care plan aligned with System 1 template. Their involvement, through informal discussions, provided valuable insights—particularly regarding the accessibility of care plan information—which helped refine and enhance the overall care-planning process. This collaboratively developed care plan served as a guiding example for occupational therapists (OTs), promoting more person-centred approaches in their documentation. Likewise, the research question emerged from a recognised need to improve co-produced, person-centred care plans for patients within inpatient mental health settings. Care plans are recognised as powerful tools in reducing coercive practices and enhancing patient experience by fostering effective communication, building therapeutic relationships, providing predictable treatment pathways and improving clinical outcomes. When implemented effectively, care plans empower patients to have greater influence over the management of their mental health, promoting a sense of value, respect and increased adherence to treatment.

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