Care Home Director

The whole home.
The detail that matters.

A guide to the software’s features, menus and recorded information.

From personal care and clinical records to rotas, visitors, meals and management evidence. Explore how Care Home Director brings the resident, the team and the day-to-day life of the home together.

> **16 areas · 163 feature and workflow entries**
> Each entry explains what the feature does, where to find it and the information it records or displays.

Generated 1 November 2026

Full catalogue · Includes restricted administration and the separately labelled eMAR development module.

YOUR GUIDE

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Menu paths are a guide to finding the screen after signing in. Your role, organisation, care-home assignments and enabled modules determine which menus are available. This document describes product capabilities; it contains no resident or staff records.

01 / FEATURE CATALOGUE · 7 ENTRIES

The home, at a glance

From the group-wide view to today’s priorities in one home, bring residents, people and outstanding work together.

Care homes & organisation switching

Where to find it: Home / Choose organisation

Open the homes you work with and switch between authorised organisations using one account.

Information recorded or displayed

Organisation membership · care-home name and contact details · location access · active home

Care-home dashboard

Where to find it: Care home → Overview

See current residents, reviews needing attention, medication reviews, staffing, today’s activities and shortcuts to daily work.

Information recorded or displayed

Resident totals · review warnings · due care · dietary concerns · room assignments · open admission and closure work

Manager overview / Shift overview

Where to find it: Care home → Shift overview

Review exceptions across the home and produce a PDF overview for management discussion.

Information recorded or displayed

Care and review exceptions · open actions · incident and safeguarding context · nutrition and hydration warnings

Rooms & occupancy

Where to find it: Care home → Rooms

Maintain rooms, assign residents and see occupied and available accommodation.

Information recorded or displayed

Room name · in-order, out-of-order or decorating status · maximum residents · bed position · description · view · WiFi · TV · phone · furniture · wetroom and ensuite facilities · wash basin, toilet and shower · resident placements · occupancy and vacancies

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Care-home details & review settings

Where to find it: Care homes → Add / Edit care home → General / Review scheduling

Maintain the home’s contact and service information and configure the review intervals used in resident workflows.

Information recorded or displayed

Address and telephone · service details · minimum observation frequency · review intervals · advance warning days · dashboard visibility · overdue-review settings

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CQC lookup, import & profile

Where to find it: Care homes → Provider import / Edit care home → General

Look up a provider’s homes, choose homes to import, and refresh the stored CQC profile, ratings and report history where the lookup service is available.

Information recorded or displayed

Provider and location identifiers · selected homes · imported address and contact details · ratings · report history · last profile sync · lookup status

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Operations

Where to find it: Manage → Operations

Find organisation tools, clinical libraries, reports and administration appropriate to your role.

Information recorded or displayed

Organisation context · permission-based tools · home-specific shortcuts

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Know the whole person

A resident record extends far beyond a name and a care plan: it brings identity, relationships, communication, background and practical arrangements together.

Resident register

Where to find it: Residents / Care home → Residents

Search residents across your permitted homes and open each person’s workspace.

Information recorded or displayed

Names · care home · admission details · current and historical resident status

Resident overview

Where to find it: Resident → Overview

Start with a resident-centred summary and navigate into care, health, documents and administration.

Information recorded or displayed

Profile summary · care context · current warnings · links to the resident’s detailed records

About the resident

Where to find it: Resident → Personal & contacts → About the resident

Record identity, admission details and who coordinates the person’s care.

Information recorded or displayed

Title and preferred name · previous names · date of birth · photograph · NHS number with check-digit validation · National Insurance number · local authority identifier · admission date, source and reason · key worker · primary care team

Personal background & communication

Where to find it: Resident → Personal & contacts → Personal background

Help staff understand the person’s background and how best to communicate with them.

Information recorded or displayed

Nationality · preferred language and interpreter needs · hearing and visual impairments · communication methods and difficulties · literacy needs · religion and faith requirements · culture and festivals · ethnicity · gender identity · sexual orientation · disability information · personal background notes

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Addresses

Where to find it: Resident → Personal & contacts → Addresses

Keep the addresses associated with a resident available within their record.

Information recorded or displayed

Address type · address lines · town · county · postcode · country · address notes

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Contacts

Where to find it: Resident → Personal & contacts → Contacts

Maintain family, next-of-kin, friend, advocate, guardian and attorney contact information.

Information recorded or displayed

Contact name · relationship and contact type · telephone · email · address · emergency and primary-contact information

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Health / professional contacts

Where to find it: Resident → Personal & contacts → Health / professional contacts

Keep the resident’s GP, pharmacy, nursing, social-work and other professional contacts together.

Information recorded or displayed

Professional role · name · organisation or practice · contact details · contact notes

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General resident notes

Where to find it: Resident → Daily care → General resident notes

Retain general information alongside the structured care records.

Information recorded or displayed

Note text · author · recorded date · resident context

Room / placement settings

Where to find it: Resident → Administration → Room / placement settings

Manage the resident’s room placement and related resident settings.

Information recorded or displayed

Assigned room · placement dates · resident settings and room history

Funding

Where to find it: Resident → Administration → Funding

Record who funds the placement and when arrangements need review.

Information recorded or displayed

Funding type · local authority · NHS, self-funded and continuing healthcare indicators · financial representative · funding start and review dates

Admission, transfers & departures

Carry information through the resident’s journey, from the first assessment to a hospital transfer or the return of personal belongings.

Pre-admission assessments

Where to find it: Care home → Pre-admissions → Create / Assessment

Build a structured assessment before admission and carry accepted information into the admission process.

Information recorded or displayed

Name and NHS number · birth, assessment and proposed admission dates · language and religion · assessor and location · understanding of needs · personal wishes · life history and significant events · interests and hobbies · dependency answers and comments · estimated care hours · manager summary

Guided admission & Continue admission

Where to find it: Care home → Admit resident / Resident → Administration → Continue admission

Work through admission in stages, save a draft and resume it. Outstanding checks can become assigned follow-up work.

Information recorded or displayed

Identity and contacts · placement · baseline care and health information · consent and documents · medication checks · admission checklist · gaps and assigned follow-ups

Initial assessments

Where to find it: Care home → Initial assessments

See which residents still need their initial assessment work completed and open the relevant record.

Information recorded or displayed

Assessment progress · missing assessments · resident and home · completion status

Hospital grab sheet / transfers

Where to find it: Resident → Administration → Hospital grab sheet / transfers

Prepare a transfer record and generate a hospital PDF or document bundle with the resident’s care information.

Information recorded or displayed

Hospital and transfer details · reason · clinical summary · medicines and allergies · contacts · supporting documents · export history

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Offboarding

Where to find it: Resident → Administration → Offboarding

Manage discharge, transfer, temporary hospital absence or death with recorded authorisation and follow-up.

Information recorded or displayed

Departure type and dates · destination · authorisation · notifications · medication and document handover · checklist · property items and their return · unresolved tasks

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Closure summary

Where to find it: Resident → Administration → Closure summary

Review the retained summary of a completed departure and its outstanding administration.

Information recorded or displayed

Completed workflow · departure details · checklist outcomes · property outcomes · retained history

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Daily care & scheduled support

Connect what a person needs with what was actually done, when it happened, who recorded it and what needs attention next.

Record care note

Where to find it: Care home → Record care / Resident → Daily care → Record care note

Capture care and observations as they happen, including mood, food, fluids and concerns for the next shift.

Information recorded or displayed

Resident · category · event time · care and observation text · mood · food and fluid intake · follow-up and handover flags · author

Resident timeline / Recent resident events

Where to find it: Care home → Care timeline / Resident → Daily care

Read daily records in sequence and filter to the person or period you need.

Information recorded or displayed

Care notes · recent events · event dates · categories · staff attribution · follow-up context

Missing daily care records

Where to find it: Care records → Missing daily care records

Identify residents without a recorded care note on the selected day.

Information recorded or displayed

Resident · care home · selected date · missing-record status

Scheduled care / Care instructions

Where to find it: Resident → Daily care → Scheduled care

Create resident-specific instructions from templates, choose schedules and maintain instruction versions. Pause, resume or end an instruction when needs change.

Information recorded or displayed

Task template · individual instructions · schedule and day parts · frequency · start and end dates · version · active or paused status

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Scheduled care dashboard

Where to find it: Care home → Scheduled care

Find care due now, overdue work and completed or exceptional tasks.

Information recorded or displayed

Resident and home · task · planned time · due and overdue status · completion history · escalation status

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Complete scheduled care

Where to find it: Scheduled care → Open task

Record completion evidence, or an authorised deferral, cancellation or other outcome, retaining the timing and explanation.

Information recorded or displayed

Planned and actual times · completion answers · outcome · notes · staff member · deferral reason · cancellation reason · escalation acknowledgement

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Scheduled care compliance

Where to find it: Operations → Scheduled care compliance

Review delivery, lateness and missed care across residents and staff.

Information recorded or displayed

Scheduled tasks · completed and missed work · delays · staff attribution · outcome history

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Care task library & template editor

Where to find it: Operations → Care task library

Maintain reusable instructions and the questions, schedules and completion options used when recording care.

Information recorded or displayed

Categories · template name and guidance · versions · completion fields · schedule options · availability

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Body maps

Where to find it: Resident → Daily care → Body maps

Mark areas of concern on the body, retain versions and attach photographs to specific points with recorded consent information.

Information recorded or displayed

Front and back body positions · area and coordinates · observation type · notes · observation and review dates · photo capture time · consent basis · recorded-by details

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Care plans, assessments & reviews

Build a structured account of needs, agreed support, risk and review decisions, with a history of how care changes.

Care plans

Where to find it: Resident → Care planning → Care plans

Create and review care-plan versions organised into domains, then sign off and export approved versions.

Information recorded or displayed

Needs · goals and outcomes · support instructions · domain sections · structured answers · review dates · reviewers · version and approval history

Care-plan domain editor

Where to find it: Care plan → Open domain

Edit the specific area of care, record a review and keep section-level changes.

Information recorded or displayed

Domain content · individual needs · support actions · structured data · review outcome · section versions

Care-plan quality review

Where to find it: Resident → Care plans → Quality audit

Review the recorded quality of a care plan and its domain-level findings. AI-assisted findings require staff review.

Information recorded or displayed

Audit result · domain findings · review context · recorded audit history

Assessments

Where to find it: Resident → Care planning → Assessments

Complete structured assessments covering nutrition, falls, pain, continence, skin, oral health and mental capacity, with review dates.

Information recorded or displayed

MUST · falls · pain · nutrition · continence · skin integrity · oral health · Waterlow · Braden · mental capacity · answers and scores · conclusions · assessment and review dates · custom assessment templates

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Risks

Where to find it: Resident → Care planning → Risks

Record risks, their controls, review decisions and evidence.

Information recorded or displayed

Risk type and severity · description · control measures · review date · review outcome · supporting evidence · reviewer

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RCN dependency / care hours

Where to find it: Resident → Care planning → RCN dependency / care hours

Record dependency across areas of daily living and see estimated care hours used in staffing planning.

Information recorded or displayed

Personal care · mobility · cognition · communication · nutrition · continence · breathing · skin · behaviour · sensory and emotional needs · assessment date · dependency score · estimated daily care hours

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Reviews

Where to find it: Resident → Care planning → Reviews

See resident review schedules and record review outcomes against the relevant area of care.

Information recorded or displayed

Review type · due date · completion · outcome · reviewer · next review

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Review warnings

Where to find it: Residents → Review warnings / Care home → Resident reviews

Find overdue and upcoming reviews, incomplete profiles and admission issues at home or organisation level.

Information recorded or displayed

Resident · warning type · due date · overdue status · linked record · admission and profile gaps

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Care-plan domains

Where to find it: Manage → Care-plan domains

Configure the domains and sections used to structure care plans.

Information recorded or displayed

Domain names · section definitions · ordering · active settings

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Health, conditions & clinical records

Bring measurements, condition-specific monitoring, legal decisions and clinical history into the same resident workspace.

Health overview & metric history

Where to find it: Resident → Health & medicines → Health overview

Review measurements over time and open a metric for its detailed history.

Information recorded or displayed

Measurement values · dates · trends · resident clinical context

Clinical summary

Where to find it: Resident → Health & medicines → Clinical summary

See a summary of the resident’s clinical records and move directly to the relevant detail.

Information recorded or displayed

Observations · assessments · risks · medicines · nutrition · consent · documents · review context

Observations

Where to find it: Resident → Health & medicines → Observations

Record and retain clinical measurements with time, notes and staff attribution.

Information recorded or displayed

Weight · height · BMI · blood pressure · pulse · temperature · respiratory rate · oxygen saturation · blood glucose · pain score · MUST score · observation time · notes

Health conditions

Where to find it: Resident → Health & medicines → Health conditions

Assign conditions, record diagnosis and severity, and tailor monitoring and responsibilities to the person.

Information recorded or displayed

Condition and template version · diagnosis status · severity · guidance · responsible staff or roles · active dates · end reason

Condition monitoring, events & reviews

Where to find it: Resident → Health conditions → Monitoring / Events / Reviews

Set monitoring frequency and thresholds, record results and significant events, and review the instructions as needs change.

Information recorded or displayed

Frequency · due dates · numerical results and units · warning and critical thresholds · symptoms · actions · escalation instructions · clinician contacts · linked incidents, medicines and documents · corrections · review decisions

Condition library & editor

Where to find it: Operations → Condition library

Maintain organisation versions of condition guidance and control their availability across care homes.

Information recorded or displayed

Template guidance · monitoring items · thresholds · notification rules · versions · care-home availability

Capacity / consent

Where to find it: Resident → Health & medicines → Capacity / consent

Record decision-specific capacity, consent, best-interest decisions, powers of attorney and advance decisions.

Information recorded or displayed

Decision and record type · capacity or consent outcome · assessment date · responsible person · evidence · restrictions · review date · linked documentation

DNACPR / ReSPECT

Where to find it: Resident → Health & medicines → DNACPR / ReSPECT

Record the presence of current resuscitation and emergency-care documents, upload evidence and review it.

Information recorded or displayed

DNACPR and ReSPECT indicators · uploaded documents · confirmation · review decisions and dates · history

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Clinical history

Where to find it: Resident → Administration → Clinical history

Follow the sequence of clinical events and their source records.

Information recorded or displayed

Event type · date and time · summary · associated clinical record · staff attribution

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Medication records & follow-up

Keep prescribed medicines, allergies, changes and review actions visible within the resident record.

Medication profile

Where to find it: Resident → Health & medicines → Medication

Record current and historic medicines, search the medicine catalogue and retain prescribing and administration instructions.

Information recorded or displayed

Medicine · strength · dose · route · frequency · start and stop dates · status · prescriber and pharmacy contacts · review due date · instructions

Allergies / medication reviews

Where to find it: Resident → Health & medicines → Allergies / medication reviews

Record allergies and reactions, and document medicine reviews and follow-up decisions.

Information recorded or displayed

Allergen · reaction · severity · identified date · review date · reviewer · review outcome · follow-up

Medication changes & history

Where to find it: Resident → Medication → Changes / History

Retain the reason and history when doses, frequency or route change, or a medicine is suspended, restarted or stopped.

Information recorded or displayed

Change type · previous and revised details · effective date · reason · recorded-by information

PRN records & refusals

Where to find it: Resident → Medication → Events

Record as-required medicine use, its effectiveness, refusal reasons and actions taken.

Information recorded or displayed

Medicine · administration or refusal time · dose · reason · effectiveness · action taken · required follow-up · outcome

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Medication follow-ups

Where to find it: Care home → Medication follow-ups

Bring PRN effectiveness checks and refusal follow-ups into a dedicated work list.

Information recorded or displayed

Resident · medicine · source event · follow-up requirement · action and outcome · completed-by details

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eMAR: rounds, stock & medicines governance

A detailed electronic medication workflow covering rounds, reconciliation, stock, witnesses and follow-up. This module is development-only and requires clinical and local go-live approval before live medicines use.

Development module

Guided eMAR navigation & help

Where to find it: Care home → eMAR → Task navigation / Help

Find medicines tasks by workflow and open contextual help explaining what to check, what to record and what happens next.

Information recorded or displayed

Task groups · page-specific guidance · keyboard-accessible help dialogs · mobile-friendly workflows

Medication Guidance & Policies

Where to find it: eMAR → Medication Guidance & Policies

Find current approved care-home policies and external NICE/CQC guidance without replacing resident-specific instructions. Authorised staff manage versions and private policy documents.

Information recorded or displayed

Policy category · exact version · approval evidence · effective and review dates · version-specific acknowledgement · review reminders · secure document download · restricted history

Medication rounds

Where to find it: Care home → eMAR round

Follow a guided resident and medicine workflow, check administration details and confirm the actual outcome.

Information recorded or displayed

Resident and medicine · scheduled time · given, refused or omitted outcome · actual time · dose · notes · administrator · witness where required

PRN administration

Where to find it: eMAR → PRN

Check verified resident-specific instructions, dose and timing limits before confirming an as-required administration and its effectiveness follow-up.

Information recorded or displayed

Indication · actual dose and time · instruction version · dose and timing checks · effectiveness review · follow-up and notes

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Effectiveness checks & refusal follow-up

Where to find it: eMAR → Check effects and refusals

Review what happened after an administration, record effectiveness and actions, and keep event follow-up separate from routine medication reviews.

Information recorded or displayed

Source administration · review due time · effectiveness · observations · action and escalation · outcome · completion details

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PRN instruction management

Where to find it: eMAR → PRN instructions

Prepare resident-specific instructions and obtain independent verification before use.

Information recorded or displayed

Prescriber · source evidence · dose and timing limits · monitoring · escalation · review date · version and verification

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Homely remedies governance

Where to find it: eMAR → Homely remedies policies

Version the home process and formulary and record independent clinical governance approval evidence; software access is not clinical authority.

Information recorded or displayed

Policy versions · formulary products · restrictions · source instructions · professional approval evidence · staff acknowledgements

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Non-prescribed suitability and ownership

Where to find it: eMAR → Non-prescribed suitability

Record resident assessments and ownership of personal OTC products without treating advice as a prescription.

Information recorded or displayed

Assessor · advice source · assessment and review dates · restrictions · resident ownership · storage · care-plan reference · assessment history

---

Homely remedies and OTC administration

Where to find it: eMAR → Give homely remedies / OTC

Record actual non-prescribed events in the existing MAR ledger, with stock traceability and escalation of historical concerns.

Information recorded or displayed

Actual dose and time · product category · policy and assessment snapshots · stock batch · effectiveness follow-up · corrections

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Medication reconciliation

Where to find it: eMAR → Reconciliation

Check incoming medicine information and verify reconciliation items before applying changes.

Information recorded or displayed

Source · medicine details · differences · verification · reconciliation status · staff member

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Medication schedules

Where to find it: eMAR → Schedules

Maintain the times and instructions that generate medication rounds.

Information recorded or displayed

Medicine · dose · route · schedule · administration times · effective dates · active status

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Home-owned remedy stock

Where to find it: eMAR → Home-owned homely remedy stock

Manage shared home stock without mixing it with medicines belonging to individual residents.

Information recorded or displayed

Formulary version · supply source · batch · expiry · receipt · quantity · return · disposal · counted balance and discrepancy reason

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Stock & orders

Where to find it: eMAR → Stock

Track batches, receipts, use, removals and reconciliation, with ordering and receipt records.

Information recorded or displayed

Batch · expiry · quantity · stock movements · reason · order and receipt status · staff attribution

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Controlled drugs

Where to find it: eMAR → Controlled drugs

Record controlled-drug counts and request independent verification by another authorised member of staff.

Information recorded or displayed

Medicine and batch · expected and actual count · discrepancy · counted-by and independent verification details

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Controlled-drug discrepancies

Where to find it: eMAR → Controlled-drug discrepancies

Investigate and review differences found in controlled-drug counts.

Information recorded or displayed

Count difference · investigation · actions · outcome · reviewer · resolution status

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Controlled-drug disposals

Where to find it: eMAR → Controlled-drug disposals

Prepare disposal requests and obtain independent witness confirmation, with the reason and staff attribution retained.

Information recorded or displayed

Medicine · quantity · disposal reason · requester · confirmation and witness information

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Administration history

Where to find it: eMAR → History

Review prescribed, homely-remedy and personal OTC events. Permission-controlled corrections retain the original record and an audit trail rather than silently replacing history.

Information recorded or displayed

Medicine category · scheduled and actual time · outcome · administrator · correction reason and history · witness confirmation

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Medication report

Where to find it: eMAR → Report

Review prescribed and non-prescribed administration and exception records over a selected period, with medicine categories kept visible.

Information recorded or displayed

Resident · medicine · medicine category · date range · administration outcomes · exceptions · recorded actions

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Medication compliance

Where to find it: eMAR → Compliance

Review due, recorded and exceptional medication work.

Information recorded or displayed

Scheduled administrations · recorded outcomes · overdue work · exception and compliance summaries

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Medication handover

Where to find it: eMAR → Handover

Carry outstanding medicines work into the next shift.

Information recorded or displayed

Outstanding administrations · follow-up · medication exceptions · handover context

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eMAR resident profile

Where to find it: Resident → Health & medicines → eMAR resident profile

Open the person’s medication workspace for current medicines and administration context.

Information recorded or displayed

Resident medicines · allergies · schedules · recent administration and follow-up context

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MAR chart

Where to find it: Resident → Health & medicines → MAR chart

Review prescribed medicines, homely remedies and personal OTC events in the existing administration record. Non-prescribed events do not create scheduled doses or missed-dose entries.

Information recorded or displayed

Medicines · medicine category · scheduled times where applicable · administration dates and outcomes · recording history

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Medication safety dashboard

Where to find it: eMAR → Safety dashboard

Bring medication exceptions, stock concerns and governance work into a single overview.

Information recorded or displayed

Overdue work · follow-up · low or expiring stock · controlled-drug exceptions · review status

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Medication reviews

Where to find it: eMAR → Medication reviews

Record medicine review outcomes and track due work.

Information recorded or displayed

Medicine · review date · review findings · decision · next review · reviewer

Prescription renewals

Where to find it: eMAR → Prescription renewals

Track renewal requests and their progress.

Information recorded or displayed

Medicine · requested and due dates · request status · follow-up · outcome

Schedule reviews

Where to find it: eMAR → Schedule reviews

Review administration schedules after medication changes.

Information recorded or displayed

Changed medicine · affected schedule · review reason · decision and completion

Exception follow-ups

Where to find it: eMAR → Exception follow-ups

Record the actions needed after medication exceptions.

Information recorded or displayed

Source administration · exception · follow-up requirement · action · outcome · responsible staff

Food, fluids & swallowing support

Connect what is planned in the kitchen with each person’s dietary needs, what was served and what was actually eaten or drunk.

Menus

Where to find it: Care home → Menus

Open the home’s nutrition workspace for planning, service and recording.

Information recorded or displayed

Menu periods · meals and choices · links to recipes, service, recording and oversight

Recipes

Where to find it: Menus → Recipes

Maintain recipes and their nutritional information for menu planning.

Information recorded or displayed

Recipe name · ingredients · portions · preparation · nutritional analysis · dietary and allergen information

Menu planner

Where to find it: Menus → Planner

Build menus by date and meal slot, with the choices available to residents.

Information recorded or displayed

Menu dates · meal slots · recipe choices · planned meals

Meal service

Where to find it: Care home → Meal service

See the people being served, their choices and dietary warnings, then record service and intake.

Information recorded or displayed

Meal and serving time · resident choice · amount eaten · drink and fluid amount · refusal or decline · dietary and allergy warnings

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Meal recording & dietary profile

Where to find it: Menus → Meal recording / Resident → Dietary profile / meal recording

Record actual meals and maintain individual dietary instructions.

Information recorded or displayed

Food and fluid intake · preferences · allergies · texture and fluid levels · feeding route · assistance and positioning · professional recommendations · clinical owner · review dates · individual fluid target

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Nutrition & swallowing / SALT plan

Where to find it: Resident → Health & medicines → Nutrition & swallowing

Record speech and language therapy guidance and carry it through to the staff-facing dietary profile.

Information recorded or displayed

Referral status · service and clinician · referral and assessment dates · feeding route · texture and fluid levels · positioning · swallowing guidance · stop-and-escalate instructions · review date · previous plan versions

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Nutrition & hydration oversight

Where to find it: Menus → Nutrition oversight

See home-wide missing records, repeated low intake, declines and progress against fluid targets.

Information recorded or displayed

Recorded meals and drinks · low intake · declines · missing entries · expected fluid progress · dietary review warnings

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Meal exceptions

Where to find it: Menus → Meal exceptions

Review meal-service exceptions and the recording or follow-up they need.

Information recorded or displayed

Resident · meal · exception · intake and decline context · follow-up notes

Dietary handover

Where to find it: Menus → Dietary handover

Give the next shift a dietary summary, including a downloadable PDF.

Information recorded or displayed

Resident dietary requirements · allergies · texture and swallowing guidance · relevant safety and intake context

Nutrition & fluid analysis

Where to find it: Resident → Health & medicines → Nutrition & fluid analysis

Review a person’s intake history and nutrition information over time.

Information recorded or displayed

Food and fluids · recorded amounts · dates · nutritional totals · targets and trends

Nutrition settings

Where to find it: Menus → Settings

Configure the home’s meal and hydration recording defaults.

Information recorded or displayed

Meal-service settings · home fluid targets · nutrition defaults

Activities, interests & wellbeing

Plan meaningful experiences, organise the people delivering them and record how each resident participated.

Activities library

Where to find it: Care home → Activities

Maintain a home library, copy templates and archive or restore activities.

Information recorded or displayed

Name · category · description · interests and tags · preparation checklist · risks · documents · active status

Create / edit activity & activity details

Where to find it: Activities → Create / Open activity / Edit

Define how an activity is delivered and the preparation and risk information staff need.

Information recorded or displayed

Purpose · instructions · resources · preparation · risks and controls · documents · template source

Activity diary

Where to find it: Activities → Activity diary

See scheduled activity sessions and arrange one-off or recurring events.

Information recorded or displayed

Session dates and times · activity · staff · provider · session status · recurrence

Create / edit session

Where to find it: Activity diary → Create session / Edit session

Arrange the practical details and resident places for an activity.

Information recorded or displayed

Activity · date · start and end times · responsible staff · provider · planned residents · preparation · recurrence · planned cost

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Session delivery, attendance & outcomes

Where to find it: Activity diary → Open session

Start, complete, postpone or cancel sessions and record participation for each resident. Produce a session sheet PDF.

Information recorded or displayed

Attendance · participation and engagement · outcomes achieved · follow-up · staff and provider attendance · actual costs · cancellation or postponement reason

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Activity providers

Where to find it: Activities → Providers → Create / Open / Edit

Maintain external providers and their assurance documents.

Information recorded or displayed

Provider and contact details · service · insurance and expiry · protected documents · visit history

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Activities & preferences

Where to find it: Resident → Daily care → Activities & preferences

Record personal interests and preferences and review the person’s activity history.

Information recorded or displayed

Interests · preferences · attendance · participation · engagement · outcomes · follow-up history

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Activity reports

Where to find it: Activities → Reports

Review delivery, resident participation and provider visits.

Information recorded or displayed

Planned and completed sessions · attendance and engagement · outcomes · provider attendance · insurance status · costs

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Activity settings

Where to find it: Activities → Settings

Configure the categories and settings used by the home’s activity workflows.

Information recorded or displayed

Categories · local activity settings · template and library options

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Visitors, families & relationships

Give the front door and family communication the same attention as the care record: know who is expected, who is on site and which resident they are visiting.

Visitor book & advance bookings

Where to find it: Care home → Visitors → Book a visit

Book family, professional and other visits, edit bookings and find previous visitor details.

Information recorded or displayed

Visitor name and email · visitor type · resident visited or home-wide visit · organisation · purpose · notes · expected date and time · booked-by staff member

Booking confirmation & cancellation

Where to find it: Visitors → Booking / Visitor's email link

Send booking details by email, optionally include a booking code and allow the visitor to cancel through their link.

Information recorded or displayed

Booking code · identity-check requirement · confirmation sent time · scheduled visit · cancellation status and time

Arrival & identity checks

Where to find it: Visitors → Sign in / Confirm arrival

Check arriving visitors against their booking or record a walk-in. Record the identity check or authorised exception.

Information recorded or displayed

Arrival time · booking match · identity checked and matched, known visitor or authorised exception · reason · checking staff member · resident link

Visitors on site & departure

Where to find it: Visitors → Visitors on site / Today’s visitor record

See the recorded on-site list for fire and safety checks, sign visitors out and review today’s visits.

Information recorded or displayed

Sign-in and sign-out times · current on-site status · visitor type and purpose · resident visited · staff who signed the visitor in and out

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Visits in the resident record

Where to find it: Visitors → Link resident / Resident → Daily care

Link a visit to the resident and retain the visit in their care-note history.

Information recorded or displayed

Visitor · resident · visit purpose · visit time · care-record entry

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Family portal

Where to find it: Resident → Personal & contacts → Family portal

Grant or revoke a contact’s access to the resident’s selected family information.

Information recorded or displayed

Approved contact · access status · selected resident updates and documents · access and viewing history

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Family feedback & review queue

Where to find it: Resident → Personal & contacts → Family feedback / Care home → Family portal review

Allow family submissions through the portal and review them before incorporating them into staff workflows.

Information recorded or displayed

Submission and contact · feedback text · submission date · review decision · reviewer · status

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Staff, HR, training & rotas

Bring staff records, skills, care-home access and the weekly rota together, with detailed coverage planning and practical staffing controls.

Staff & HR / Home staff

Where to find it: Manage → Staff & HR / Care home → Staff

Maintain a group-wide staff directory, assign people to homes and open their employment record.

Information recorded or displayed

Name · photo · contact details · role · active status · home assignments · job title · organisation memberships

Staff personal & employment record

Where to find it: Staff & HR → Open staff member

Keep personal and organisation-specific employment details together with appropriate access controls.

Information recorded or displayed

Address · date of birth · telephone · National Insurance and DBS reference · employee number · payroll ID · job title and department · employment type and status · contracted hours · employment dates · line manager · notes

Qualifications, documents & emergency contacts

Where to find it: Staff record → Qualifications / Documents / Contacts

Retain qualifications, protected employment files and the people to contact in an emergency.

Information recorded or displayed

Qualification and awarding body · achieved and expiry dates · certificate reference · employment contract and document type · issue and expiry dates · emergency contact relationship, phone and address

Staff onboarding & offboarding

Where to find it: Staff record → Lifecycle checklists

Record the checks and actions associated with joining or leaving the organisation.

Information recorded or displayed

Checklist item · lifecycle stage · completion status · completion details · staff employment context

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Users & access

Where to find it: Manage → Users

Manage accounts, roles and access to the organisation and its care homes.

Information recorded or displayed

Name and email · role · active status · organisation membership · home access

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Staff training

Where to find it: Staff & HR → Training

Maintain courses and staff training records, arrange training events and review the training matrix.

Information recorded or displayed

Course and category · mandatory requirements · status · completion and expiry dates · certificate reference · event date · attendees

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Rota

Where to find it: Care home → Rota

Create and edit shifts, copy a day, view weekly staff hours and compare planned staffing with estimated resident care needs.

Information recorded or displayed

Staff member · shift date · start and end times · shift hours · daily and weekly totals · resident dependency and estimated care-hour requirements

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Coverage planner

Where to find it: Rota → Coverage planner

Create coverage blocks on a time line and allocate staff to the required headcount, roles and current training.

Information recorded or displayed

Block dates and times · required staff count · role requirements · training or skill requirements · assigned staff · gaps

Weekly coverage overview

Where to find it: Rota → Weekly coverage overview

Move between weeks and inspect each day’s planned coverage blocks and staffing gaps.

Information recorded or displayed

Week · daily coverage blocks · required and assigned staff · role and training coverage

Rota templates

Where to find it: Rota → Templates / Save this week as a template

Save reusable weekly patterns and apply them with optional saved staff assignments.

Information recorded or displayed

Template name and description · blocks and timings · staffing requirements · saved assignments · target week

Safe-staffing gap alerts

Where to find it: Rota → Coverage / Action queue / Notifications

Flag gaps in configured future coverage blocks and bring them to managers’ attention. Resolved coverage closes the related work.

Information recorded or displayed

Headcount gaps · role and training gaps · affected home and period · priority · acknowledgement · resolution

Staffing operations: leave & absence

Where to find it: Rota → Staffing operations

Submit leave requests, record absence and approve or decline leave.

Information recorded or displayed

Leave type · start and end dates · reason · request status · decision · absence type · expected return · notes

Open shifts & approvals

Where to find it: Staffing operations → Open shifts and approvals

Let staff claim open offers and allow a manager to check and approve allocation.

Information recorded or displayed

Offered shift · dates and times · claimant · offer status · manager decision

Approved hours & payroll export

Where to find it: Staffing operations → Download payroll CSV

Export approved weekly hours for use in a separate payroll process.

Information recorded or displayed

Staff ID · name and email · week starting · approved hours · approval records

Shift-based access

Where to find it: Sign in → Not on shift

Apply configured shift access windows and show upcoming shifts when access is outside the permitted window.

Information recorded or displayed

Rota dates and times · care home · permitted access window · upcoming shifts

Handovers, incidents & action tracking

Turn important information into visible work, preserve the decisions made and help the next shift pick up where the last one finished.

Handovers

Where to find it: Care home → Handovers

Prepare a structured outgoing handover with a snapshot of relevant care and operational issues, acknowledge it and download a PDF pack.

Information recorded or displayed

Shift and staff · handover notes · incidents · safeguarding · actions · medication and resident reviews · nutrition and fluids · flagged care notes · acknowledgement

My handovers

Where to find it: Profile menu → My handovers

Open the handovers relevant to you in your accessible home.

Information recorded or displayed

Handover history · shift context · acknowledgement status

Incidents (home register)

Where to find it: Care home → Incidents / Resident → Daily care → Incidents

Record incidents, add investigation updates and record actions, outcomes and management review.

Information recorded or displayed

Type · resident · date and time · location · severity · description · immediate action · hospital admission · investigation · outcome · reviewer · closure

Incident reporting

Where to find it: Care home / Organisation → Incident reporting

Review incident patterns and outcomes over a selected period.

Information recorded or displayed

Incident type · severity · date range · resident and home · status · investigation and outcome

Safeguarding

Where to find it: Care home → Safeguarding

Record concerns and preserve investigation, evidence, outcome and management review through closure.

Information recorded or displayed

Concern type · resident · date · details · actions · investigation and evidence · outcome · manager review · status

Action queue

Where to find it: Care home → Outstanding tasks / Operations → Action queue

Work through shared operational actions arising from care, reviews, incidents and other workflows.

Information recorded or displayed

Source record · title and details · home · priority · due date · assignee · status · follow-up and completion

Outstanding tasks

Where to find it: Top bar → Tasks

See outstanding work relevant to the user and navigate to the underlying task.

Information recorded or displayed

Task category · due status · priority · source · outstanding counts

Notifications

Where to find it: Top bar → Notification bell / Notifications

Read in-app alerts, open the related work and acknowledge alerts that require a response.

Information recorded or displayed

Notification category · title and message · priority · source link · read and acknowledgement status

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Manager trends

Where to find it: Organisation → Manager trends

Review management patterns across resident and care information.

Information recorded or displayed

Care-home and period filters · resident and clinical trends · underlying operational context

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Reports, documents & evidence

Move from individual records to management information, with filtering, exports and a history of the evidence produced.

Report Centre & report viewer

Where to find it: Care home / Operations → Reports

Browse report categories, keep favourites, set filters and open detailed reports. Use PDF, Excel, CSV, print and charts where supported by that report.

Information recorded or displayed

Report category and description · filters · selected columns · favourites · export profiles · export history

Resident & occupancy reports

Where to find it: Report Centre → Residents / Operational

Review who is living in the service, admissions and bed availability.

Information recorded or displayed

Resident List · Current Occupancy · Admissions · Daily Resident Register · Missing Daily Care Records

Care-plan & clinical reports

Where to find it: Report Centre → Care Planning / Clinical / Medication

Review care-plan reviews, falls, nutritional risk, weight changes, medicines and allergies.

Information recorded or displayed

Care Plans Due for Review · Overdue Care Plans · Falls Report · MUST Assessment Report · Weight Change Report · Medication Reviews Due · Resident Allergy Report

Condition reports

Where to find it: Report Centre → Clinical

Review condition records, monitoring, significant events and the use of templates.

Information recorded or displayed

Resident Condition Summary · Condition Monitoring Compliance · Condition Event Report · Overdue Condition Reviews · Condition Template Usage

Care delivery reports

Where to find it: Report Centre → Care delivery

Examine planned versus recorded care, lateness and staff completion patterns.

Information recorded or displayed

Resident Task History · Missed and Late Care · Staff Task Compliance · planned and actual times · outcomes and delays

Lifecycle & property reports

Where to find it: Report Centre → Residents / Operational

Track planned departures, hospital stays, completed departures and remaining property or follow-up.

Information recorded or displayed

Discharges · Planned Discharges · Residents In Hospital · Recent Discharges · Recent Transfers · Recent Resident Deaths · Outstanding Offboarding Tasks · Property Awaiting Return · Average Length of Stay · Discharge Destinations

Activity, training & action reports

Where to find it: Report Centre → Activities / Staff / Compliance

Review participation, provider visits, staff training expiry and outstanding actions.

Information recorded or displayed

Activity Delivery · Resident Activity Participation · Activity Provider Visits · Training Expiry Report · Outstanding Actions

Supporting evidence pack

Where to find it: Reports → Pilot evidence pack

Generate a care-home and date-scoped PDF of supporting operational evidence.

Information recorded or displayed

Selected home and period · care and governance evidence · export record

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Resident documents

Where to find it: Resident → Documents → Resident documents

Upload protected documents, retain review dates and record document reviews. Authorised users can download the files.

Information recorded or displayed

Document title and type · file · upload date and author · review due date · review history · consent and legal documents

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Audit history / Audit trail

Where to find it: Resident → Administration → Audit history / Manage → Audit trail

Review recorded changes and activity with attribution and resident context.

Information recorded or displayed

Date and time · user · action · record · changed fields and previous values where recorded · resident and organisation

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Compliance overview

Where to find it: Manage → Compliance

Review organisation compliance information and record management review.

Information recorded or displayed

Review status · compliance areas · findings · recorded review details · supporting operational information

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Organisation, account & support

Manage the organisation around the care: access, billing records, personal preferences, practical help and support conversations.

My organisation

Where to find it: Manage → My organisation

Maintain organisation details and the configuration used by its homes and users.

Information recorded or displayed

Organisation name and contact information · provider details · organisation settings

Organisation permissions

Where to find it: Manage → Permissions

Set organisation-level permission overrides for the different roles and functions.

Information recorded or displayed

Role · permission · default access · organisation override · permitted care and management actions

Billing settings

Where to find it: Organisation → Billing

Maintain organisation or home billing profiles and review billing estimates and settings.

Information recorded or displayed

Legal and trading names · accounts email and telephone · billing address · VAT number · purchase-order reference · billing mode · estimates · profile completeness

Profile and settings

Where to find it: Profile menu → My profile

Maintain account details, password, two-factor authentication, appearance and notification preferences.

Information recorded or displayed

Name and email · password settings · two-factor setup · theme choice · notification categories and preferences

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Login history

Where to find it: Manage → Login history

Review recorded sign-in attempts and access activity.

Information recorded or displayed

User · date and time · outcome · IP and request context where recorded

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Policies

Where to find it: Manage / Profile menu → Policies

Read the platform’s Cookie, Privacy, Terms of Use and Disclaimer pages.

Information recorded or displayed

Platform policy text and usage information

Help Centre

Where to find it: Top bar → Help

Search help and open guidance for the screen you are using.

Information recorded or displayed

Help articles · categories · searchable content · page-specific guidance

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Support Centre

Where to find it: Help / Operations → Support

Raise support cases with attachments, follow replies and see status changes.

Information recorded or displayed

Category · subject · description · attachments · conversation · ticket status · notifications

Platform administration

Specialist tools for authorised platform administrators. These sit alongside the care-home features and are restricted to the appropriate support roles.

Restricted administration

Groups CRM

Where to find it: Platform administration → Groups CRM

Create and maintain care-provider organisations and their access.

Information recorded or displayed

Organisation and contact details · group configuration · access and membership context

Billing & Pricing

Where to find it: Platform administration → Billing & Pricing

Configure organisation pricing and overrides, calculate distinct qualifying residents for monthly billing, and retain pricing snapshots for finalised periods.

Information recorded or displayed

Default and overridden pricing · organisation billing terms · qualifying resident counts · monthly periods · pricing snapshots · change history

Platform settings

Where to find it: Platform administration → Platform settings

Maintain platform-wide options available to support administrators.

Information recorded or displayed

Platform configuration · setting values · enabled options

Master care task templates

Where to find it: Platform administration → Jaguar care task templates

Create and maintain master care-task definitions for organisation use.

Information recorded or displayed

Task guidance · completion fields · schedule options · versions · publishing and availability

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Master condition templates

Where to find it: Platform administration → Jaguar condition templates

Maintain and publish the master health-condition library.

Information recorded or displayed

Condition definitions · monitoring items · thresholds · notification rules · versions and publication

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Report administration

Where to find it: Platform administration → Report administration

Create, version and maintain report definitions and layouts.

Information recorded or displayed

Report name and category · columns · filters · calculated fields · permissions · export settings · templates and versions

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Scheduled task monitor & task history

Where to find it: Platform administration → Scheduled task monitor

Inspect scheduler runs and the generation and history of scheduled resident care tasks.

Information recorded or displayed

Run time and status · generated care tasks · resident and home · task events · completion and escalation history

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Default permissions

Where to find it: Platform administration → Permissions

Maintain the default permission settings for roles.

Information recorded or displayed

Role or rank · permission · default allowed status

System backups

Where to find it: Platform administration → System backups

Review backup runs and use authorised backup, restore, rename and delete controls.

Information recorded or displayed

Backup name · run status · date and time · backup history · available restore records

Support administration & categories

Where to find it: Platform administration → Support

Manage support tickets, replies, attachments and the categories customers use.

Information recorded or displayed

Ticket category · customer and organisation · messages · attachments · status · category settings

Help article management

Where to find it: Help Centre → Manage

Maintain the guidance displayed throughout the application.

Information recorded or displayed

Article title and content · category · related page or route · publication settings

AVAILABILITY & SCOPE

Clear detail.
Clear expectations.

Access follows responsibility

The catalogue describes the software’s screens and workflows. Your organisation, care-home assignments, permissions and enabled modules determine what you see. Platform administration is restricted to authorised support roles.

Medicines & assisted review

eMAR is a development module, not approved for live medicines management. It requires clinical, pharmacy and local operational approval. AI-assisted care-plan quality findings require professional review.

Alerts & workforce

Care alerts use the in-app notification system; nutrition and hydration warnings also appear in oversight and handovers. Visitor booking emails are a separate workflow. Rota coverage describes planned staffing; approved-hours exports support a separate payroll process.

Evidence & product scope

Structured records and audit history support evidence gathering. They do not establish DSCR assurance or regulatory certification. Automated report delivery, payment collection and production NHS or pharmacy integrations are outside the features described here.