|  |
| --- |
| **Personalised Care Plan*****This is not a legally binding document but a supportive tool which may be amended at any time. This plan should be completed with the patient/relevant others by a professional with the required training & skillset*** |
| **PATIENT DETAILS** |
| Name: Title Given Name Surname | Date of Birth: Date of Birth |
| NHS Number: NHS Number | Gender: Gender(full) |
| Ethnicity: Ethnic Origin | Main Language: Main Language |
| Home Address: Home Full Address (single line)  |
| Home Telephone No.: Patient Home Telephone  | Mobile Telephone No.: Patient Mobile Telephone  |
| **GP DETAILS** |
| GP Name: Usual GP Title Usual GP Forenames Usual GP Surname |
| GP Surgery: Usual GP Organisation Name | GP Telephone: Usual GP Phone Number |
| GP Address: Usual GP Full Address (single line)  |
| **KEY CONTACT (Ideally Next Of Kin/ Lasting Power of Attorney)** |
| Name: Free Text Prompt  | Role: Free Text Prompt |
| Telephone Number: Free Text Prompt  |  |
| **LIVING ARRANGMENTS** |
| **Home** (Alone)  (With Someone)  | **Care Home** (Nursing)  (Residential)  | **No fixed abode**    |
| What support does the patient have living at home? e.g. care package |
| **SIGNIFICANT DOCUMENTS** |
| Lasting Power of attorney health & wellbeing | Yes  No  Name: |
| Lasting Power of attorney finance | Yes  No  Name: |
| Advance decision to refuse treatment | Yes  No  |
| Advance statement of wishes & preferences | Yes  No  |
| **GOLD STANDARDS FRAMEWORK** | Single Code Entry: On gold standards palliative care framework  |
| **DNACPR Status – Complete if applicable**  | Single Code Entry: Not for attempted cardiopulmonary resuscitation  |
| **ANTICIPATORY CLINICAL MANAGEMENT PLAN (ACMP)** |
| **CLINICAL GUIDANCE FOR URGENT/ EMERGENCY CARE AND TREATMENT** |
| **The key aim of future clinical care which has been shared with the patient or Next Of Kin/Carer** |
| For all active treatment  | Palliative approach  | Care of the dying  |
| **What clinical events can you anticipate?** |  |
| **Specific guidance to manage this event** |  |
| **RECOMMENDATION FOR TREATMENT ESCALATION & TRANSFER TO A HOSPITAL**  |
| Hospitalisation if deemed helpful or essential to prolonging life |   |
| Management within the home setting to be the primary aim where possible |   |
| Express wish not to be transferred/admitted to hospital even if life at risk |   |
| *Comment if helpful:* |
| **PATIENT’S PERSEPECTIVE (Or Next Of Kin/ Carer if patient is unable to engage)** |
| **What does the patient understand about their current illness?** |
| ***“What matters to me”*** e.g. who might the patient want with them, their spiritual needs etc? |
| **PREFERRED PLACE OF CARE** (In case of serious or progressive illness) | Single Code Entry: Preferred place of care - home...  |
| **PREFERRED PLACE OF DEATH** (In case of terminal illness) | Single Code Entry: Preferred place of death – home… |
| **BASELINE FUNCTION** |
| **OXYGEN SATURATION (if relevant)** | Single Code Entry: Blood oxygen saturation (calculated)...  |
| **MOBILITY (X)** | Fully mobile  Wheelchair Walking aids  Bedbound  |
| **WHO PERFORMANCE SCORE** | Single Code Entry: WHO performance score.. |
| **COMMON GERIATRIC ASSESSMENT DOMAINS (Applicable in frail and care home patients)** |
| Physical | Mobility/balance | Functional |
| Psychological/mental | Medication review | Socioeconomic/environmental |
| **Please identify if there are any specific issues or unmet needs against the domains as applicable**Unmet need:Proposal: |
| No immediate unaddressed needs with regards to the domains of the CGA |  |
| **INFORMATION TO ASSIST PATIENTS WITH PARTICULAR NEEDS** *e.g. Visual, hearing, Activities of Daily Living,* |
|  |
| **CURRENT MEDICAL PROBLEMS – Only include those problems relevant to this plan** |
| Active Problems Significant PastProblems  |
| **Allergies & Adverse Drug Reactions** |
| Allergies  |
| **SHARING THIS CARE PLAN & NOTIFICATIONS (X)** |
| Patient and or carers |  |
| Ambulance Service (NWAS) | Code from EMIS |
| Out of Hours Provider  | Code from EMIS |
| Other |  |
| **CARE PLAN AGREEMENT** |
| **Healthcare Professional who has completed the care plan**  |
| Name: | Free Text Prompt  | Role: | Free Text Prompt  |
| Date: | Long date letter merged  |
| **Was the patient involved in the development of this plan?**  | **Yes**   **No**   |
| If “No” how was the plan developed? |
| Confirmation that the patient/ nominated deputy agrees with the care plan, its contents and for it to be shared with professionals who may be involved in their future care. **For patients who lack capacity** Name of the person above: Relationship to the Patient: | **Yes**   **No**   |
| Consent to share  | Single Code Entry: Consent given for sharing end of life care coordination recordSingle Code Entry: Withdrawal of consent for sharing end of life care coordination record Single Code Entry: Best interest decision taken for sharing end of life care coordination record Single Code Entry: Consent given by appointed person with lasting power of attorney for personal welfare (Mental Capacity Act 2005) for sharing end of life care coordination record  |