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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Past  Problems | | | | | | | | | | | | | | | |
| **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 record  Single 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 | | | | | | | | | | | | | |