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