**NHS Continuing Healthcare Care Plan and Agreed Care Package**

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| **PATIENT DETAILS:**Name:Address:Post Code:Telephone:Date of Birth: | **GP DETAILS:**Name: Address:Post Code:Telephone: |
| **NEXT OF KIN / FIRST CONTACT:**Name: Relationship:Address:Telephone: Mobile: | **WARD CONSULTANT:**Name:Liaised with GP regarding End of Life Care:Date: |
| **DISTRICT NURSING TEAM: Referred Yes / No:**Tel. No: Referred to Late Call: | **MACMILLAN NURSE:**Telephone Number:Referral Yes / No: |
| **LIST OF OTHER PROFESSIONALS INVOLVED IN CARE:** | **CARE PROVIDER / NURSING HOME (if known):**Contact Name:Address:Telephone:Fax: |
| **ACCESS TO HOME:****Key Safe Number:** | **OCCUPATIONAL ASESSMENT COMPLETED (Yes / No)****Equipment recommended / ordered:** |

**SUMMARY CARE PLAN:**

**BACKGROUND INFORMATION:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | **NHS NUMBER:** |  |
| **PATIENT NEED** | **INPUTS REQUIRED** | **NUMBER AND LEVEL OF STAFF REQUIRED** | **TIME REQUIRED** | **DAYS** | **NIGHTS** |
| **Maintaining a Safe Environment.**Do they live alone?Any animals in the home? |  |  |  |  |  |
| **Communication.**Interpreter required? |  |  |  |  |  |
| **Breathing**Oxygen ordered? |  |  |  |  |  |
| **Hygiene** |  |  |  |  |  |
| **Nutrition:**Who will provide?ShoppingPreparation of FoodAssistance with diet & Fluids |  |  |  |  |  |
| **Continence:**Provided with sufficient required continence products?Who will provide laundry service? |  |  |  |  |  |
| **Mobility:**Falls Risk?Equipment? |  |  |  |  |  |
| **Skin Integrity:**Necessary equipment delivered? |  |  |  |  |  |
| **Emotional and Psychological / Perception of Health Status.**Is individual aware of diagnosis & prognosis? |  |  |  |  |  |
| **Medication:**Who will administer?Who will re-order medication?Concordance with Medication? Allergy? |  |  |  |  |  |
| **Mental Health & Cognition:** |  |  |  |  |  |
| **Sleeping:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **NAME:**  | **DOB:** | **NHS NUMBER:** |
| **Assessor’s Name:****Title:** | **Signature:** **Date:** |
| **FOR COMPLETION BY FUNDED CARE TEAM ONLY:** |
| **Start date:****Care Provider:** | **Review date:** **4 weeks 3 months**  **12 months Other**   |
| **END DATE:****Care terminated care plan changed and new care plan in place care paused from / to insert dates and reason and inform care provider:****NAME: TITLE:****SIGNATURE: DATE:**  |