**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?  Shopping  Preparation of Food  Assistance 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:** | | | | | |