(NAME OF AGENCY)

ADDRESS:

....

....

....

TELEPHONE NUMBER: ....

EMERGENCY OUT OF HOURS CONTACT: ....

SERVICE USER'S PERSON CENTRED CARE PLAN

Service User's Name: .... Date of Birth: ....

Preferred Name: .... Religion: ....

Address: ....

....

....

Post Code: ....

Date Service Commenced: ....

I agree with this plan for my care.

Service User's Signature: ....

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(NAME OF AGENCY)

PERSON CENTRED CARE PLAN DC-054

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PART 1
GENERAL INFORMATION

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PERSON CENTRED CARE PLAN DC-054

PART 1 GENERAL INFORMATION

1.1 SERVICE USER'S PERSONAL INFORMATION

Name: .... Date of Birth: ....

Address: .... G.P/Tel. No: ....

.... Social Worker/Tel. No:...............................

Tel. No:.. Next of kin/Tel. No:....................................

Ethnic Origin: .... Relationship: ....

Key holder: .... Emergency Contact Tel No:....................

Signed Home Care Co-ordinator:............................. Date of Referral: ....

SPECIFY TIME ALLOCATED TO MEET SERVICE USER'S PLAN

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Lunch							
Teatime							
Bedtime							

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PART 1 GENERAL INFORMATION

1.2 CONTACT DETAILS

Carer and family involvement and other social contacts and relationships

Next of kin	**Other contact relationship**
Name:	Name: ....
Relationship:	Relationship: ....
Address:	Address: ....
....	....
....	....
....	....
Tel: (day)	Tel: (day) ....
(night)	(night) ....
In event of illness contact at night? YES/NO	In event of illness contact at night? YES/NO

Other contact relationship	**Other contact relationship**
Name:	Name: ....
Relationship:	Relationship: ....
Address:	Address: ....
....	....
....	....
....	....
Tel: (day)	Tel: (day) ....
(night)	(night) ....
In event of illness contact at night? YES/NO	In event of illness contact at night? YES/NO

All personal records are confidential

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PART 1 GENERAL INFORMATION

1.3 SERVICE USER'S PROFILE

The purpose of the Service User's profile is to learn about the life of the person, if they are prepared to share the information with you. The process establishes a good relationship between Home Care Staff and Service User. This can be an important source of information to be considered for the Service User's Plan.

Name:
I am prepared to share with people who will be assisting me, information about me including: previous work or social interests, hobbies, leisure pursuits, family background, cultural / religious beliefs.
…………………………………………………………………………………………………… Continue on additional sheet.

All personal records are confidential.

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1.4 ARRANGEMENTS FOR ENTERING THE SERVICE USER'S HOME

Staff should record here the arrangements agreed with the Service User for entering their home.

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1.5 SERVICE USER'S GENDER PREFERENCE FOR THEIR CARE DELIVERY

During the assessment of the Service Users needs and preferences they should be asked for their preference in relation to the delivery of their care, or no preference.

A record should be made here of the Service Users preferences.

My gender preference for the delivery of my care is:

Gender: ……………………………………………..

Where resources do not enable the Agency to meet the Service Users wishes. The reason why it is not possible should be explained the Service User.

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1.6 SCHEDULE OF TASKS AND TIMES

Schedule of tasks and times							
Tasks	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Bedroom							
Assistance with getting in and out of bed							
Making a bed							
Changing bed linen							
Bathroom							
Assistance with bathing washing, shaving and oral hygiene							
Toileting							
Personal Care							
Assistance with Dressing							
Assistance with Transferring							
Assistance with walking							
Health							
Manage medications							
Nursing care							
Pressure area care							
Physical therapy							
Occupational therapy							
Speech therapy							
Meals							
Plan menus and prepare							
Breakfast							
Lunch							
Tea							
Assist with feeding							
Laundry							
Wash, dry and fold clothing and linens							
Ironing							
Cleaning							
Wash, dry and store dishes and utensils after meals							

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1.6 SCHEDULE OF TASKS AND TIMES

Schedule of tasks and times							
Clean sink, stove, counters, refrigerators							
Sweep floors							
Wash floors							
Empty and take out rubbish to bin							
Shopping							
Prepare shopping list and carry out shopping							
Purchase food							
Store items as required							
Other Tasks							
Walking the dog							
Pets							

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PART 2
INITIAL ASSESSMENT
HEALTH AND WELLBEING
DAILY LIVING

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PART 2 ASSESSMENTS

2. I. INITIAL ASSESSMENT

2.2 Areas to be covered by the assessment.

Please identify the area of need required by the Service User in the boxes blow in sections HW and DL. (Mark with a tick ✓)

Health and Wellbeing

HW-1 Personal care and physical well-being		HW-2 Communication and Sensory needs		HW-3 Medical History		HW-4 Medication	
HW-5 Allergies and drug interactions		HW-6 Mobility, dexterity and falls		HW-7 Skin integrity		HW-8 Dental and oral care	
HW-9 Hearing		HW-10 Vision		HW-11 Foot care		HW-12 Mental health and cognition	
HW-13 Behavioural Difficulties		HW-14 Diet, nutrition, eating, drinking and swallowing		HW-15 Continence promotion		HW-16 Pain Management	
HW-17 Comfort, Rest and Sleep		HW-18 Breathing		HW-19 Wishes Upon Death		HW-20 Sexuality	

Daily Living

DL-1 Equality diversity religious and cultural observance		DL-2 Social activities		DL-3 Physical activity		DL-4 Community involvement	
DL-5 Contact with family and friends		DL-6 Money management		DL-7 Dressing			

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2.3 HEALTH AND WELLBEING ASSESSMENT

(All sections of the assessment must be completed)

HW-1 Personal Care and Physical Well-Being

1.1 Is the Service User able to perform any of the following?
Circle as appropriate

Wash	YES / NO	Dress	YES / NO
Step into a bath /shower	YES / NO	Apply make up	YES / NO
Put shoes on	YES / NO	Go to the toilet	YES / NO
Get up in the morning	YES / NO	Go to bed at night	YES / NO

1.2 Please give a written indication of your perception of the Service User's ability to care for themselves in addition to the above.

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PERSON CENTRED CARE PLAN DC-054

2.3 HEALTH AND WELLBEING ASSESSMENT

HW-2 Communication and Sensory Needs

Does the Service User use any aids to assist with communication? YES / NO
Please specify e.g. loop, picture boards, writing pad, sign language, finger signing, , Interpreter etc.

Date of assessment: ……………………… Staff signature: …………………….

HW-3 Medical History

Please specify as much detail as possible of the Service User's medical history.

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-4	**Medication**	
HW-4.1	Does the Service User currently take medication? If YES please see MAR sheet.	YES / NO
HW-4.2	Please complete the following where the Agency has responsibility for Service Users Medication when taking up the service:	

Medication	Frequency of dosage	Dosage

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-4.3 Does the Service User experience difficulties with self-medication? YES / NO
If yes, please specify:

Date of assessment: ……………..…… Staff signature: …………………….

HW-4.4 Has a Medication Risk Assessment been carried out? YES / NO
(For people who wish to self-medicate.)

Date of assessment: ……………………… Staff signature: …………………….

HW-4.5 Does the Service User require prompting with their medication? YES / NO
If yes, please specify:

HW-5 Allergies and Drug Interactions

HW-5.1 Does the Service User have any problem with allergies and drug reactions? YES / NO
If yes, please specify:

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-6 Mobility Dexterity and Falls

HW-6.1 Does the Service User have any problem with mobility or falls? YES / NO
If yes, please specify and also record any mobility aids used:

Date of assessment: ……………………… Staff signature: …………………….

HW-6.2 Has a fall's assessment been carried out? YES / NO

Date of assessment: ……………………… Staff signature: …………………….

HW-7 Skin Integrity

HW-7.1 Does the Service User have any skin breaks, bruises or skin conditions? YES / NO
If yes, please specify:
(Include: Water pressure ulcer risk and prevention)

Date of assessment: ……………………… Staff signature: ………………………….

HW-7.2 Has a Waterlow Assessment, C4-104, been carried out? YES / NO

Date of assessment: ……………………… Staff signature: ………………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-8 Dental and Oral Care

HW-8.1 Does the Service User require assistance with dental and oral care? YES / NO
If yes, please specify e.g. if dentures used:

Date of last visit to dentist: ……………………… Staff signature: …………………….

HW-8.2 Has a dental and oral assessment been carried out? YES / NO

Date of last assessment: …………………. Staff signature: …………………….

HW-9 Hearing

HW 9.1 Does the Service User require assistance with their hearing? YES / NO
If yes, please specify:
(Include: hearing aids, and maintenance)

Date of assessment: ……………………… Staff signature: ………………………….

HW-9.2 Has a hearing test been carried out? YES / NO

Date of assessment: ……………………… Staff signature: ………………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-10 Vision

HW-10.1 Does the Service User require assistance with their vision? YES / NO
If yes, please specify:
(Include: spectacles hearing aids, and maintenance)

Date of assessment: ……………………… Staff signature: ………………………….

HW-10.2 Has an eye test been carried out? YES / NO

Date of last eye test: …………………. Staff signature: …………………….

HW-11 Foot Care

HW-11.1 Does the Service User require assistance with foot care? YES / NO
If yes, please specify: (Include use of chiropody service)

Date of last appointment: …………………. Staff signature: …………………….

HW-12 Mental Health and Cognition

HW-12.1 Does the Service User have any problems with mental health, or cognition?
YES / NO
(Include Alzheimer's dementia and emotional needs) If yes, please specify:

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-13	**Behavioural Difficulties**	
HW-13.1	Does the Service User require assistance with the management of their behaviour? If yes, please specify:	YES / NO
Date of assessment: ………………………		Staff signature: …………………….

HW-14	**Diet, Nutrition Eating, Drinking and Swallowing**	
HW-14.1	Does the Service User have any problems with their diet or weight, nutrition, If yes, please specify:	YES / NO
Date of assessment: ………………………		Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-14.2 Has a Nutritional Assessment, been completed? YES / NO Date of assessment: ……………………… Staff signature: …………………….
HW-14.3 Has a referral been made to the SALT team? YES / NO Date of Referral: ……………………… Staff signature: …………………….
HW-14.4 Does the Service User have any dietary preferences? YES / NO If yes, please specify: Date of assessment: ……………………… Staff signature: …………………….
HW-14.5 Does the Service User have any difficulties with, eating, drinking or swallowing? YES / NO Please specify: Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-15 Continence Promotion

HW-15.1 Does the Service User require assistance to manage continence? YES / NO
If yes, please specify:

Date of assessment: ……………………… Staff signature: …………………….

HW-15.2 Has a referral been made to a continence advisor? YES / NO

Date of Referral: ……………………… Staff signature: …………………….

HW-16 Pain Management

HW-16.1 Does the Service User require assistance with pain management? YES / NO
If yes, please specify:

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-17 Comfort, Rest and Sleep

HW-17.1 Does the Service User have any preferences for bed comfort, rest and sleep? YES / NO
Please specify:

Date of assessment: ……………………… Staff signature: …………………….

HW-18 Breathing

HW-18.1 Does the Service User require assistance to manage their breathing? YES / NO
If yes, please specify:

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-19 Wishes Upon Death

W-19.1 Do you have any instructions or special arrangements for your end of life care?
YES / NO
If yes, please specify in the sections below:

HW-19.2 Multi- Agency Care:

HW-19.3 Symptom Management:

HW-19.4 Personal Care:

HW-19.5 Nursing Care:

HW-19.6 Spiritual and Cultural Arrangements:

HW-19.7 Funeral Arrangements:

HW-19.8 Emergency Arrangements:

HW-19.9 Place of Death / Ambience:

HW-19.10 Have you made a will: YES / NO

Name of Solicitor and address:

Date of assessment: ……………………… Staff signature: …………………….

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2.3 HEALTH AND WELLBEING ASSESSMENT

HW-20 Sexuality

How does the Service User Express their sexuality (e.g. type of clothes, makeup)?

Is there any information or assistance staff can provide to assist the Service user in expressing their sexuality.

Date of assessment: ……………………… Staff signature: …………………….

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2.4 DAILY LIVING ASSESSMENT

DL-1	Equality, Diversity, Religious and Cultural Observance
DL-l.1	Does the Service User require assistance with practising their religion or cultural requirements? YES / NO If yes, please specify: Date of assessment: ……………………… Staff signature: …………………….
DL-l.2	Are there any actions required to ensure that the Service User is not discriminated against with regard to the protected characteristics of the Service User. If yes, please specify: YES / NO Date of assessment: ……………………… Staff signature: …………………….

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2.4 DAILY LIVING ASSESSMENT

DL-2	Social Activities	
DL-2.1	What kind of interests and social activities is the Service User interested in? Please specify:	YES / NO
Date of assessment: ………………………		Staff signature: …………………….

DL-3	Physical Activity	
DL-3.1	What kind of physical activities is the Service User interested in? Please specify:	YES / NO
Date of assessment: ………………………		Staff signature: …………………….

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2.4 DAILY LIVING ASSESSMENT

DL-4	Community Involvement	
DL-4.1	Does the Service User wish to be involved in community activities? Please specify Service Users wishes:	YES / NO
	Date of assessment: ………………………	Staff signature: …………………….

DL-5	Contact with Family and Friends	
DL-5.1	Does the Service User require assistance to maintain contact with family and friends? Please specify Service Users wishes:	YES / NO
	Date of assessment: ………………………	Staff signature: …………………….

DL-6	Money Management	
DL-6.1	Does the Service User require assistance to manage their money? Please specify:	YES / NO
	Date of assessment: ………………………	Staff signature: …………………….

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2.4 DAILY LIVING ASSESSMENT

DL-7	**Dressing**	
DL-7.1	Does the Service User require assistance with dressing? Please specify:	YES / NO
Date of assessment: ………………………		Staff signature: …………………….

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PART 3
OUTCOME OF
THE ASSESSMENT

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PART 3 OUTCOME OF THE ASSESSMENT

Tick the box which applies to the assessed needs and preferences identified in Part 2 Health and Wellbeing and Daily Living assessment. A recorded Yes indicates that assistance is required. These must be included in the Service Users Person Centred Care Plan. There should be no blank boxes.

HEALTH AND WELLBEING

Reference	Area Assessed	Support plan required	
HW-01	Personal care and physical well-being	Yes	No
HW-02	Communication and Sensory Needs	Yes	No
HW-03	Medical History	Yes	No
HW-04	Medication	Yes	No
HW-05	Allergies and Drug Interaction	Yes	No
HW-06	Mobility, Dexterity and Falls	Yes	No
HW-07	Skin Integrity	Yes	No
HW-08	Dental and Oral Care	Yes	No
HW-09	Hearing	Yes	No
HW-10	Vision	Yes	No
HW-11	Foot Care	Yes	No
HW-12	Mental Health and Cognition	Yes	No
HW-13	Behavioural Difficulties	Yes	No
HW-14	Diet, Nutrition, Eating, Drinking and Swallowing	Yes	No

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Reference	Area Assessed	Support plan required	
		Yes	No
HW-15	Continence Promotion		
HW-16	Pain Management		
HW-17	Comfort Rest and Sleep		
HW-18	Breathing		
HW-19	Wishes Upon Death		
HW-20	Sexuality		

DAILY LIVING

Reference	Area Assessed	Yes	No
DL-01	Equality, Diversity, Religious and Cultural Observance		
DL-02	Social Activities		
DL-3	Physical Activity		
DL-04	Community Involvement		
DL-05	Contact with Family and Friends		
DL-06	Money Management		
DL-07	Dressing		

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PART 4
SERVICE USER'S
PERSON CENTRED
CARE PLAN

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PART 4 SERVICE USER PERSON CENTRED CARE PLAN

Tick the box which applies to the assessed needs and preferences identified in Part 2 Health and Wellbeing and Daily Living assessment which is recorded Yes and where assistance is required. These must be included in the Service Users Person Centred Care Plan:

4.1 Health and Wellbeing

HW-1 Personal care and physical well-being		HW-2 Communication and Sensory needs		HW-3 Medical History		HW-4 Medication	
HW-5 Allergies and drug interactions		HW-6 Mobility, dexterity and falls		HW-7 Skin integrity		HW-8 Dental and oral care	
HW-9 Hearing		HW-10 Vision		HW-11 Foot care		HW-12 Mental health and cognition	
HW-13 Behavioural Difficulties		HW-14 Diet, nutrition, eating, drinking and swallowing		HW-15 Continence promotion		HW-16 Pain Management	
HW-17 Comfort, Rest and Sleep		HW-18 Breathing		HW-19 Wishes Upon Death		HW-20 Sexuality	

4.2 Daily Living

DL-1 Equality Diversity Religious and Cultural Observance		DL-2 Social Activities		DL-3 Physical Activity		DL-4 Community Involvement	
DL-5 Contact with Family and Friends		DL-6 Money Management		DL-7 Dressing			

There should be a separate plan for each identified Service User need or requirement.

Where there are no needs or requirements identified a record should be made in the relevant box ‘not required’ and the date. There should be no blank boxes.

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4.1 HEALTH AND WELLBEING

HW-1 Personal Care and Physical Well-Being
Service to be provided including Service User's preferences **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-2 Communication and Sensory Needs
Service to be provided including Service User's preferences   **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-3 Medical History
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-4 Medication
Service to be provided including Service User's preferences   **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-5 Allergies and Drug Interactions
Service to be provided including Service User's preferences **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-6 Mobility and Dexterity
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-7 Skin Integrity
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-8 Dental and Oral Care
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-9 Hearing
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-10 Vision
Service to be provided including Service User's preferences   **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-11 Foot Care
Service to be provided including Service User's preferences   **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-12 Mental and Health Cognition
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-13 Behavioural Difficulties
Service to be provided including Service User's preferences **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PERSON CENTRED CARE PLAN DC-054

4.1 HEALTH AND WELLBEING

HW-14 Diet, Nutrition Eating, Drinking and Swallowing
Service to be provided including Service User's preferences: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-15 Continence Promotion
Service to be provided including Service User's preferences: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-16 Pain Management
Service to be provided including Service User's preferences: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-17 Comfort Rest and Sleep
Service to be provided including Service User's preferences: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-18 Breathing	
Service to be provided including Service User's preferences: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………	
Outcome: Describe what the plan is designed to achieve: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………	

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4.1 HEALTH AND WELLBEING

HW-19 Wishes Upon Death
Service to be provided including Service User’s preferences: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ……………………… Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.1 HEALTH AND WELLBEING

HW-20 Sexuality
Service to be provided including Service User's preferences: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………
Outcome: Describe what the plan is designed to achieve: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………

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4.2 DAILY LIVING

DL-1 Equality Diversity, Religious and Cultural Observance
Service to be provided including Service User's preferences: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.2 DAILY LIVING

DL-2 Social Activities
Service to be provided including Service User's preferences: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………
Outcome: Describe what the plan is designed to achieve: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………

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4.2 DAILY LIVING

DL-3 Physical Activity
Service to be provided including Service User's preferences: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.2 DAILY LIVING

DL-4 Community Involvement
Service to be provided including Service User's preferences: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.2 DAILY LIVING

DL-5 Contact with Family and Friends
Service to be provided including Service User's preferences: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………   Staff signature: …………………….** **Signature of Service User: ………………………………………**

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4.2 DAILY LIVING

DL-6 Money Management
Service to be provided including Service User's preferences: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………
Outcome: Describe what the plan is designed to achieve: **Date of Plan:** ……………………… **Staff signature:** ……………………. **Signature of Service User:** ………………………………………

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4.2 DAILY LIVING

DL-7 Dressing
Service to be provided including Service User's preferences: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**
Outcome: Describe what the plan is designed to achieve: **Date of Plan: ………………………** **Staff signature: …………………….** **Signature of Service User: ………………………………………**

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PART 5
RISK ASSESSMENTS

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PART 5 RISK ASSESSMENTS

5.1 RISK ASSESSMENT FORM - SERVICE USER'S PROPERTY

Date	Nature of the risk identified	Action required to minimise the risk	Progress of the actions taken	Signed by Manager
	Pathways and drives Detail ……..			
	Doorways, entry and exits			
	Entrance			
	Stairways and stairwells			
	Electrical hazards			
	Tripping, falling and stumbling			
	Kitchens			
	Bathrooms			
	Other areas			

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PART 5 RISK ASSESSMENTS

5.2 HOUSEHOLD SAFETY HAZARD CHECKLIST

Service User's Name: ....

Completed by: ....

Designation:..

Item	Hazard Yes / No	Observation	Action Taken
General			
Loose, worn or torn carpets			
Cluttered potential tripping areas			
Slippery floors			
Heavy and unsteady furniture			
Poor ventilation			
Cluttered wardrobes / store cupboards			
Kitchen			
Cooker taps left on			
Loose pan handles			
Drying clothes on cooker door			
Slippery floors			
Hot fat left on cooker			
Food left uncovered			
Household cleaners not stored correctly			
Blunt can openers			
Ragged can edges			
Bathroom			
Heaters / radios in bathroom			
Unsafe handrails to bath			
Unsafe handrails to toilet			
No slip mat in bath			
Living Room			
Unguarded fires			
Location of portable heaters			
Multi-plug adapters			
Electrical appliances and lighting			
Trailing wires			
Bedroom			
Poor ventilation			
Portable heaters			
Electric blankets			
Candles			
Outside			
Unsafe steps			
Uneven paths			
Entrance handrails unsafe			
Any Other areas unsafe			

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PART 5 RISK ASSESSMENTS

5.3 RISK ASSESSMENT - MOVING AND HANDLING FORM

Name of Service User: **Preferred name:** **Date of birth:**	**Name of assessor:** **Job title:** **Signature of assessor:** **Date of assessment:**	
Nature of handling risk identified or the nature of disability	**Equipment or method to be used**	**Continuing suitability of method and review of effectiveness**
1. Rising from chair		
2. Standing		
3. Walking		
4. Toileting		
5. Transfers - general		

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PERSON CENTRED CARE PLAN DC-054

PART 5 RISK ASSESSMENTS

5.3 RISK ASSESSMENT - MOVING AND HANDLING FORM

Name of resident: **Preferred name:** **Date of birth:**		**Name of assessor:** **Job title:** **Signature of assessor:** **Date of assessment:**
Nature of handling risk identified or the nature of disability	**Equipment or method to be used**	**Continuing suitability of method and review of effectiveness**
6. Transfers to and from bed		
7. Movement in bed		
8. Falling - no sign of injury		
9. Falling - injury suspected		

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PART 5 RISK ASSESSMENTS

5.4 GENERAL RISK ASSESSMENT FORM

Nature of the assessment: …………………………………………………………….………… …………………………………………………………………………… **Date of assessment:** ………………………..		**Name of assessor:** …………..…………………………….. **Job title:** ……………………..…………..….……………… **Signature of assessor:** …………………………………..	**Signed:** **Service User / relative / representative**
Nature of risk identified	**Method used to reduce or manage the risk**	**Review of effectiveness**	

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PART 5 RISK ASSESSMENTS

5.5 SMOKING RISK ASSESSMENT

<table>
<tr><td>Service User's Name</td><td colspan="3"></td></tr>
<tr><td>Name of Assessor</td><td colspan="3"></td></tr>
<tr><td>Designation of assessor</td><td colspan="3"></td></tr>
<tr><td>Service User’s Address</td><td colspan="3"></td></tr>
<tr><td>Location of assessment</td><td></td><td>Date of assessment</td><td></td></tr>
<tr><td>Source: Who smokes and how many smokers are there in the property?</td><td colspan="3"></td></tr>
<tr><td>Quantity: Indicate the approximate number of cigarettes smoked during home carer’s visit</td><td colspan="3"></td></tr>
<tr><td>Type of tobacco smoke: e.g. cigarette, pipe.</td><td colspan="3"></td></tr>
<tr><td>When does the service user tend to smoke and for how long?</td><td colspan="3"></td></tr>
<tr><td>Any other relevant circumstances:</td><td colspan="3"></td></tr>
<tr><td>Adverse effects on staff:</td><td colspan="3"></td></tr>
<tr><td>Actions required to reduce risks:</td><td colspan="3"></td></tr>
</table>

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PART 6
SERVICE USER'S
PLAN AGREEMENT

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PERSON CENTRED CARE PLAN DC-054

PART 6 SERVICE USER'S PLAN AGREEMENT

Service User's Name: ……………………………….……….

1. **Our agreement with you**
   We agree to provide the services and assistance stated in the objectives of your Service User's Plan.

2. **Service User and / or representative**
   I have read the contents of my Care Plan and agree with the services and assistance that is to be provided for me.

   Signed Service User / representative: …………………………… Date: ………………

---

3. **Risk-taking**
   Following the assessment of your needs, we have identified that there are some risks in providing our services to you.

   The risks are described below:

RISK-TAKING

I have read about the risks involved and agree to my plan of care.

Signed: ……………………………… Service User / representative Date: …………………

Signed: ……………………………… Manager Date: ……..……………

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PART 7
REVIEW PROCEDURE AND SERVICE USER'S PLAN RECORDS

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PART 7 REVIEW PROCEDURE AND SERVICE USER'S PLAN RECORDS

7.1 Review of Service User's Plan Form Review Date: …..….........................

All areas of Service User's Plan to be reviewed with Service User or representative where possible.

Area E.G. HW-01 Communication & Sensory needs	**Specify any changes to Service User's Plan**	**Continue with outcome or Specify new outcome**

Signed Service User / representative:............................ Signed Staff Member: ....

Date of next review: ....

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PERSON CENTRED CARE PLAN DC-054

PART 7 REVIEW PROCEDURE AND SERVICE USER'S PLAN RECORDS

7.2 REVIEW NOTES

Service User Name: .... Date of review: ....

Review attended by:

Service User ☐ Relative / Advocate ☐ Keyworker ☐ Staff Member ☐

Others please specify: ....

Review co-ordinated by: .... Date of next planned review: ....

Notes of review
REASON FOR HOLDING REVIEW .... CURRENT SITUATION / UPDATE SINCE LAST REVIEW .... WHAT ACHIEVEMENTS HAVE BEEN MADE? .... REASONS FOR CHANGES TO SERVICE USER'S PERSON CENTRED CARE PLAN .... CONCERNS REGARDING CURRENT CARE PROVISION .... Continue on additional sheet

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PART 7 REVIEW PROCEDURE AND SERVICE USER'S PLAN RECORDS

7.3 RECORD OF REVIEWS

DATE OF LAST REVIEW	DATE OF NEXT PLANNED REVIEW	SIGNATURE

This review record is to be kept up to date by an authorised Member of Staff.

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PART 7 REVIEW PROCEDURE AND SERVICE USER'S PLAN RECORDS

7.4 RECORD OF ASSESSMENTS

Areas to be assessed include risk, mental capacity, nutrition, smoking, etc.

DATE OF LAST REVIEW	DATE OF NEXT PLANNED REVIEW	SIGNATURE

This record of assessments is to be kept up to date by an authorised Member of Staff

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PART 8
OTHER FORMS AND CHARTS

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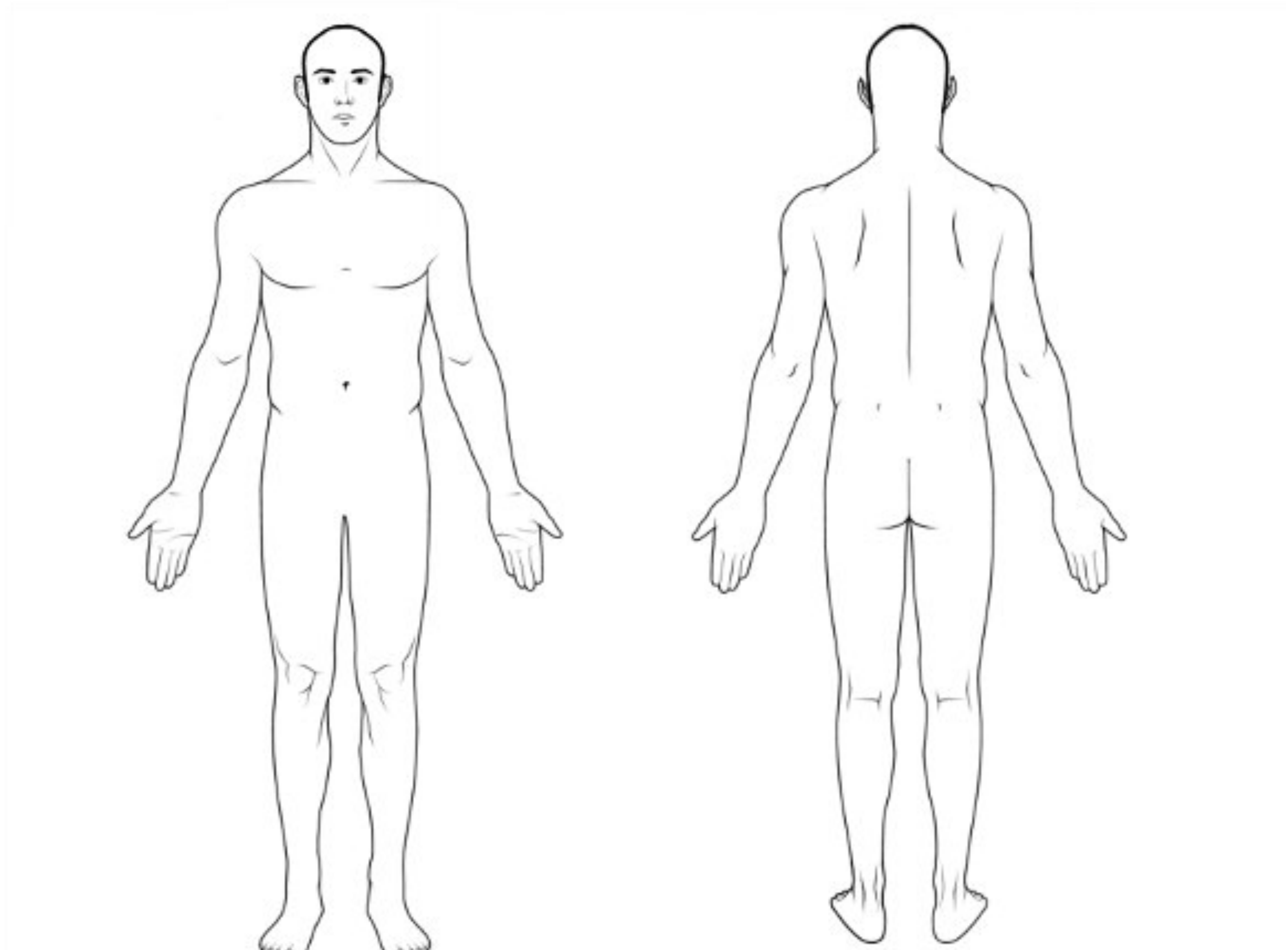
PART 8 RECORD SHEETS FORMS AND CHARTS

8.1 BODY CHART – (To use with HW-06 Skin Integrity).



Number the affected area or wound on the body with a description below and write an accompanying plan of care where needed.

1		5	
2		6	
3		7	
4		8	

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PART 8 RECORD SHEETS FORMS AND CHARTS

8.2 Evaluation of Person Centred Care Plan Review		
Service User's Name:		
HW=Health and Wellbeing	DL=Daily Living	
To be completed by:……………………………………………...		
Area E.G. HW-01 Personal Care and Physical Well-Being	**Comments on Outcome**	**Signature / Date**

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8.2 Evaluation of Person Centred Care Plan Review		
Service User's Name:		
HW=Health and Wellbeing	DL=Daily Living	
To be completed by:……………………………………………....		
Area E.G. HW-01 Personal Care and Physical Well-Being	**Comments on Outcome**	**Signature / Date**

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8.3 External Appointments Records

Name of Service User: ....

Please complete for any appointment attended outside of the home, e.g. dentist, hospital out patients.

Date	Appointment Details

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8.3 External Appointments Records

Name of Service User: ....

Please complete for any appointment attended outside of the home, e.g. dentist, hospital out patients.

Date	Appointment Details

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8.4 Family Communication

Significant contact with family or advocates

Name of Service User: ………………………………………………………..

Date	Communication	Signature

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8.4 Family Communication

Significant contact with family or advocates

Name of Service User: ……………………………………………………..

Date	Communication	Signature

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