Care Home Resident Summary Care Plan

Consent
I consent to personal information for active administration of my hospital discharge to be shared with my care home **Name (Print): …….** **Signature: …… Date: ……**
Are there any Safeguarding concerns? YES / NO Comments:

Date of Last Update:	Updated By:
Patient's Name: **Preferred Name:** **NHS No.**	**Date of Birth:** **Age:** **Gender:** Male / Female **Religion / Spirituality:**
Care Home Name: Phone Number: Address: Postcode:	**GP Name:** **Surgery:** GP Phone Number: Address: Postcode:
Is there legal Power of Attorney for Health and Welfare? YES / NO Name: Relationship: Phone Number: Address: Postcode:	**Is there legal Power of Attorney for Property and Finance?** YES / NO Name: Relationship: Phone Number: Address: Postcode:
Next of Kin Name: Relationship: Phone Number:	Address: Postcode:

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Does the person have decision making capacity?	YES / NO
Is there DOLS?	YES / NO
Admission to hospital in the last 30 Days?	YES / NO
If yes, provide details including whether admitted from hospital or home:	
Number of attendances to hospital in last 12 months:	
Were there any recurrent episodes of illness identified from the reasons for hospital admission or recent GP visits?	
Relevant past medical history	
Any drug allergies? Any recent illness or treatment?	

Observations - baseline readings:

	Result	Date	Signature	Print Name	Job Title
Oxygen Saturation					
Heart Rate					
BP Sitting BP Standing					
Respiratory Rate					
Blood Sugar					
Height					
Weight					

Medications

Is the resident on more than 4 medicines?	YES / NO
Please attach a copy of the MAR sheet	YES / NO
Please list medication not included on the MAR sheet *(e.g. medications bought over the counter, herbal / homeopathic preparations)*	
Can the resident swallow their medications?	YES / NO
Is the resident on oxygen?	YES / NO
If yes, at what level of oxygen therapy?	

Infection Prevention and Control - Is the person an infection risk?

MRSA	YES / NO
Diarrhoea	YES / NO
Other	YES / NO
If yes, please give details (including results and treatment)	

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Cognition	
Is the person living with Dementia?	YES / NO
Is there a history of challenging behaviour?	YES / NO
Details (*e.g. aware of surroundings, prone to wandering)*	

Falls	
Is the person at risk of falls?	YES / NO
Has a referral been made to the Falls Team?	YES / NO
Number of Falls in the last year:	
Details:	

Skin Integrity	
Is skin intact?	YES / NO
Pressure areas:	
Existing reported?	YES / NO
Wounds:	
Water low scale score:	
Details of any dressings:	
Is any pressure relieving equipment in place?	YES / NO
Type of mattress / air mattress: Other equipment:	

Nutrition	
Any unintentional weight loss?	YES / NO
Details:	
Any swallowing problems?	YES / NO
Details:	
Is Salt / dietician assessment indicated?	YES / NO
What is their MUST score?	
Mealtime information (*e.g. can the person feed themselves, slow to eat, on supplements)*	

Communication:		
Speech:	Dentures:	YES / NO
Hearing:	Hearing Aids:	YES / NO
Eyesight: *(e.g. good, poor, glasses)*		
Memory / Mood: Confirmed diagnoses of dementia? YES / NO		

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Previous Function

Previous transfers and mobility, including stairs:

Current transfers and mobility:

Mobility equipment / aids – please tick:

Standing Hoist		Sling Hoist		Wheelchair		Frame	
Handling Belt		Sliding Sheet		Chair Raisers		Commode	

Continence

Details of continence assessment – please tick:

Urinary incontinence	Faecal incontinence	Catheter	Stoma

Does the person have a supply of continence products? YES / NO

If applicable, please state indication / reason for long term indwelling urinary catheter:

Date of last assessment for ongoing need: Date catheter was last changed:

End of Life Care

Is the person known to the Palliative Care Team?	YES / NO
MacMillan Nurse / MCCT Co-ordinator: Phone Number:	
Is there an Anticipatory / Advance Care Plan? Review Date:	YES / NO
Is there a DNACPR form?	YES / NO
Preferred place of care at End of Life:	
Preferred place of Death:	
Has pain been assessed using a pain assessment tool?	YES / NO

Comments / Actions:

Specialist Teams Involved with Patient - please include as applicable:

		Physio		SaLT	
		Airways		Dietician	
		Heart Failure		Respiratory Team	
		Tissue Viability		Psychiatry	
Care Home Pharmacist (if on 4 + medicines or problems swallowing medicines)		Continence Service		Continuing Care for CHC consideration	

Other Services, please list: