Personalised Care Plan (PCP) – PART ONE Medical Plan

Key Worker:		**Contact No:**			
Surname:		**Date of Birth:**		**Patient's Address:**	
First Name:		**NHS Number:**		**Patient's Tel:**	
PCP Part One Completed	*Date:* *Name / Signature:*	**PCP Part One Reviewed**	*Date:* *Name / Signature:*	*Date:* *Name / Signature:*	*Date:* *Name / Signature:*
GP: **Surgery Address:** **GP Phone:** **GP Email / Fax:**					
Preferred Place of Care:	*Date:*	*Date:*	*Date:*		
Has a Treatment Escalation Plan (TEP) been completed	*Date:* Y / N	*Date:* Y / N	*Date:* Y / N		
Where in the patient's house is the TEP kept?					

Usual Presenting Health Condition

Past Medical History	*Option: Attach a "Short Pt Profile"*			
Current Medications	*Option: Attach a current prescription sheet or Patient Profile.* *Include: Over the counter Medication and supplements*			
	Warfarin:	Y / N	**Allergies:**	
Current Medical Condition(s) ***Severity / Staging Treating Consultant***				
Patient's Baseline Performance Status :	*For Example: Presenting Symptoms / Activity Levels re ADL's and details re Care Package*			
	Care Agency:		Tel:	
Previous Reason for Admission(s)	*Highlight where admissions were appropriate / avoidable. Time off previous admissions AM / PM OOH / Weekends*			
Previous interventions that have prevented Admission(s)	*For example ACAH, Home First, Medication changes.*			

Rescue / Anticipatory Medication in House	*For Example Antibiotics / Steroids. Nebuliser and medication. Opiate for SOB Mgt.* • *Include details re doses / regimes specific to patient.*	
	Where are above Rescue Medications kept?	

Does the patient manage their own Medications: *i.e. Could the patient reliably take additional Acute Medication alongside current medications / blister pack.*	Y / N	**If No who manages the patients Medications:** *For example family member / Care Agency. What would need to be in place to ensure Acute Medications taken as prescribed*	

Baseline Status and Observations

	Date	Date	Date	Date
Temperature:				
Heart Rate:				
Known AF: Y / N **Pacemaker:** Y / N **ICD:** Y / N **Telehealth:** Y / N				
Blood Pressure:				
Respiratory Rate:				
Oxygen Y/N **Nebuliser** Y/N **Suction Unit** Y/N **NIV** Y/N **CPAP** Y/N				
Sp02 Oxygen				
Inspired Oxygen: *(Litres)*				
Weight: *Heart failure*				
Frailty Score:				

Communication and Baseline Cognition

Does the patient have Mental Capacity? Y / N If **No** ensure this is documented in the patient's notes **AND** who the PCP has been discussed with to determine patient's wishes. For example: POA / NOK / Best Interest / MDT.	**Power of Attorney for Health and Welfare:** Y / N Name: Relationship Contact Details: Tel: Registered: **Y / N** Copy on GP Notes: **Y / N**	**Power of Attorney for Finance:** Y / N Name: Relationship Contact Details: Tel: Registered: **Y / N** Copy on GP Notes: **Y / N**

Communication: *Include information re: Hearing Aids, Glasses, and Speech as well as baseline cognition*

First Language / Religion / Cultural Beliefs

Next of Kin (NOK) or First / Emergency Contact Details	
Next of Kin Details **Name:** **Relationship to patient:** **Address:** **Telephone numbers:** • **Home** • **Work** • **Mobile**	**Additional Emergency Contact details** **Name:** **Relationship to patient:** **Address:** **Telephone numbers:** • **Home** • **Work** • **Mobile**

Other Relevant Information	
Other Services Patient known to – including Contact Details *For Example: District Nursing Team, Community Matron, Specialist Nurses, ACAH. Home Front. Chemist.*	
Name and Role	**Contact Details**
1.	
2.	
3.	
4.	
5.	
6.	
Any additional information related to Appropriate Admission Avoidance discussed with patient to date:	