Peter is 35 years old. He was recently involved in a car accident which has left him wheelchair bound. He currently lives in a third floor flat. Since the accident he has found it difficult to adapt to the changes he now faces; he is struggling to do things around his flat, goes out rarely, and seems to be suffering with depressive symptoms.

Write a care plan for Peter, ensuring you include an assessment of his needs, how you will meet his needs and the other agencies (if any) you will need to include in his care.

A meeting was arranged with Peter Harris last week and when we met there were a lot of issues to be covered and discussed. After a lengthy conversation and sharing suggestions, Peter has a clearer plan of achievable goals and actions that are needed to assist him in moving forward in his life. Peter, who is 35 years old, has just recently been discharged from the hospital spinal cord injury unit where he spent just over 3 months as a result from sustaining an incomplete T5 spinal cord injury after a road accident. Peter's level of paralysis is paraplegic, however, his prognosis of a partial recovery looks promising as the swelling and fluid retention around the spinal cord has reduced and Peter has since experienced, although presently very faintly, some motor responses. Peter also has a slight increase in sensory responses in sporadic areas of his limbs. There is hope for further motor, sensory and reflex improvement in the next year, however, doctors have realistically indicated that it is unlikely that Peter will regain full recovery of mobility.

During the rehabilitation period Peter spent under the care of the spinal cord injury unit the nursing team worked with Peter discussing personal care routines in order to avoid complications commonly associated with spinal cord injuries. They have also spent time helping Peter know the essentials of rolling out of bed correctly and transferring himself in and out of his wheelchair. As well as physiotherapy Peter also received help by a speech language pathologist in ensuring his level of breathing from his diaphragm was sufficient. Peter said that the nursing team at the hospital had been amazing in their level care and were very encouraging. He said that they reassured him that by regaining his confidence, developing skills and working with all the available rehabilitation programmes there is no reason why he couldn't live as independently and to the fullest. Peter admits that he struggles to remain in that same positive frame of mind now he is alone at home. My initial concern, which I shared with Peter and was in agreement with, was the necessity to adapt to the changes and maintain a positive outlook throughout his recovery which, potentially, will be long. Helping Peter come to terms with what has happened is one of the first steps especially as Peter recognises that he could be experiencing the early stages of

depression. Peter admits he feels despondent and is finding himself either wanting to stay in bed or at times getting highly anxious and overwhelmed about things.

Peter has been living alone since he moved out from his long term ex-girlfriend two years ago and, at present, on a flat on the 3rd floor which he bought out rightly 10 years ago as an investment between Peter and his sister, originally as an investment to rent using money from his father's will after he died. Peter's mother is still alive but has poor health with early stages of emphysema and lives 105 miles away. He has one older sister, Suzanne who is married with two children. Peter and Suzanne have a good relationship and helps in anyway she possibly can although travelling can be difficult as she has to share a car with her husband and lives just about 20 miles away. She did stay with Peter at his home for the first initial few days when Peter was discharged from hospital; however, she has to juggle her own family responsibilities. Peter is very uncertain what to do in regards to housing and feels he needs to discuss fully all the possible options available. As he owns his own property Peter has been told that he is not eligible for social housing. He is not too worried about that but does not know whether to remain in his flat that does have a lift but also has a large step at the main entrance. At the moment he has someone to help him down the step when he is being given transport but does not know what he will do in the future if he drives eventually himself. It will mean applying to the freeholder for permission for ramp adaptations in the foyer and another concern of Peter is the risk of fire and evacuation. A fire may affect the electrics of the lift. His other idea is to move from his present home, rent it out and use the money to rent a home at ground floor level. Either way he will need major adaptations done in his home.

As it remains Peter is now no longer in employment (although he says everyone has been really considerate and thoughtful) as it is unknown when and how he will return and subsequently just recently applied for Disability Allowance. Prior to Peter's accident he was working in computers for a small company and he has expressed that he could continue work of a similar kind from home in the future. Furthermore suggestion was made by himself that in the distant future he could go back to studying again or learn a hobby as he was always interested in creative pursuits but never really made it a priority before. Peter says he is trying to adjust and positively move forward including keeping his mind active but still feels numb by all that has happened. Previously, Peter was very into sports particularly water sports and cycling. Generally, Peter has regarded himself as an outgoing and independent person with a wide circle of friends but feels he cannot face seeing them with the exception of one close friend. He said that some of his friends want to raise money on his behalf but its something that he feels so unable to feel part of at the moment.

Care-coordinator, Carolyn Thomas

3rd November 2011

Health & Social Care Plan

My Details		
First Name: Peter	**Surname:** Harris	**Date of Birth:** 21/11/76
Address: 22 Northumberland House, 237 Ballards Lane, North Finchley. London. **Postcode:** N3 1LZ		**Telephone :** 0208 371 9478 **:** 07810 582 330
NHS Number: 122880433-9		**Aldrich Spinal Injury Hospital Number:** 7864312
Religion: Jewish *Comments*: Does not practice Judaism strictly but does still observe abstaining from eating pork and shellfish.		**Ethnicity:** British *Comments:* Mother is from France and therefore second language is French.

Information for Service Providers

Difficulties I experience: ☒ Mobility

Comments: I sometimes take a while answering the door and telephone.

Allergies/Reactions: Peanuts, eggs, white bread or pasta, adhesive from medical plasters.

Comments: I am not severely allergic but I am likely to get a headache and inflammation in my joints.

Conditions: Mildly Asthmatic.

Comments: Dust levels need to kept to a minimum (to any who calls round to clean) and window in bedroom is always kept slightly open (except in extreme winter) please don't close it as I won't be able to open it as I have difficulty in reaching.

Care Team Provider

Care-Coordinator: Jo Smith	**Contact Telephone:** 0208 422 9108 / Textphone: 0208 422 7861
Agency: Four Leaves Care	**Address:** 201 Finchley Road, Swiss Cottage. London. NW8 4BU

Emergency out of hours: 07780 442 130

Care Assessment – Needs and objectives

Level of Care Plan: ☐ Standard ☒ Enhanced

Start date of Care Plan: 2nd November 2011 **Review of Care Plan:** 16th December 2012

In partnership and agreement with Mr Peter Harris the purpose of the Care Plan is to provide initial help and support for him with the ultimate goal of enabling him to positively move forward in his live in order to live independently and with dignity. Mr Peter Harris hopes in time the level of home care will eventually reduce and ultimately be self-sufficient in his personal and home care routines.

Physical Health Care

Indentified needs, goals and risk assessment.	**Plan of appropriate action and whom is responsible.**	**Aims of what is to be achieved and intention of outcome.**	**Date of start**	**Date of Review/ Assess**
Peter needs continued Physiotherapy. He does receive physiatry, consultancy and physiotherapy from Aldrich Spinal Cord	An occupational therapist would organise assess being referred to a physiotherapy at his primary care provider. Will contact	The doctor at Aldrich Hospital has been very positive in his rehabilitation outlook for Peter. With	4/11/11	2/12/11

Injury Hospital but this is not on a regular basis. Peter needs much more frequent physiotherapy from his local primary care provider.	O.T.	constant and regular physiotherapy Peter will improve. It is essential to build his physical stamina and aim the maximum rehabilitation he can		(4 wks)
Peter is unsure of whether he is correctly rolling out of bed and transferring in and out of wheelchair, dressing etc. Peter has many questions and he says many of the things that the hospital showed him is now vague and would like to spend time discussing the issues again.	An occupational therapist would organise an arrangement with nursing team. Peter said he will also call Aldrich hospital to see if an appointment can be made as well.	To become more independent and feel confident that he is practicing routines himself which are correct.	8/11/11	22/11/11 (2 Wks)
Not enough soft cushioning on the seat of Peter's wheelchair or comfortable neck rest. Risk of pressure sores and neck strain. Peter needs other equipment as well	a) Needs a soft fleece cushion. b) support cushion. Needs to see occupational therapy to review equipment Peter needs.	Feel more comfortable in the time he spends in his wheelchair and avoid causing physical complications.	4/11/11	/12/11 (3 Wks)
Would like to buy a home gym. Peter would like to maintain and strengthen his arms, torso and inner core muscles at home in his leisure.	Needs to be confirmed by the rehabilitation nursing team (or local primary care physiotherapist if he has made contact) that it is both a safe way of exercising and what exercise programmes would be safe to do.	Would have enough room in Peter's bedroom and providing it is in accordance to Peter's physiotherapy programme it would help him to keep in good physical condition,	02/11/11	14/12/11 (6 Wks)
Peter so far has reliant on a daily visit by the District nurse in helping his with bowel evacuation and changing of his catheter.	Establish an effective bowel management regime for him self. Needs to discuss these issues by making an appointment	Will help Peter in overcoming in what he describes as 'big confidence obstacle' he wants to overcome and	07/11/11	19/12/11

This is one of the upsetting aspect for Peter and is anxious (which is undermining his confidence) that he will have an embarrassing accident when he out of with people. Peter really wants to take charge of this area of his personal care.	either with Aldrich Hospital nursing team or the head district nurse at local primary care hospital. Peter has reflex bowel dysfunction with very minor sensory feeling which he hopes could therefore slowly improve. Also wants to change his own catheter which at present is using a condom catheter.	manage urinating and bowel movements himself.		(6 Wks)
Care Program Approach				
Indentified needs, goals and risk assessment.	**Plan of appropriate action and whom is responsible.**	**Aims of what is to be achieved and intention of outcome.**	**Date of start**	**Date of Review/ Assess**
Peter is feeling quite low at times and is unable to move out from under from the feelings he has including feeling irritable and frustrated. He is finding it hard to be interested in things and be motivated. He swings from feeling helpless and sad to being anxious and despairing.	Arrangements to have to be made for Peter to receive help from a psychologist and talk through issues, possibly with Cognitive Behavioural Therapy. His G.P. should refer him to a psychologist.	Peter needs to find a way to come out from the emotional/ psychological issues he is facing. Gaining coping skills and having a positive outlook is essential to moving forward and live to the fullest and independently despite huge changes in his life.	4/11/11	18/11/11 (2 Wks)
Although friends and family have been very supportive, Peter feels unable to see them and instead wanting to avoid them. Has	There is a support group by people who have had spinal cord injury linked to the hospital and they meet once a month at a	Build his social activity slowly and build a support network of trustworthy friends and family around	5/11/11	19/11/11

become isolated	member's house 12 miles from Peter. The people to contact is a man called Joe on 0208 998 0124. Peter will call him.	him. Get to know people who have gone through similar spinal cord injuries.		(3 Wks)
Peter recently saw his G.P. as he had a urinary tract infection shortly after coming out of hospital. He was put on a course of antibiotics and knows the importance of drinking a lot of fluids to prevent the problem again. However whilst he was there Peter discussed that he is feeling low. The doctor is reluctant (as Peter is too) to put him on a course of anti-depressants and is the last resort. His G.P. did suggest eating a good diet and getting as much exercise.	Make an appointment to see a nutritionalist to tailor make a diet that Peter will realistically follow. Peter enjoys cooking and intends to eventually prepare all meals himself. At present the kitchen does not have adequate adaptations but is an aim in the Care Plan. Peter also needs some exercise and Peter has expressed wanting to swim. This aim is listed also elsewhere in Care Plan. Peter if he wishes will make phone call but he is not sure at present.	To avoid being put on anti-depressants and make every practical measure to improve Peter's emotional and psychological welfare.	-	28/12/11 (8 Wks)
The area of concern is when Peter can occasionally feel despairing and overwhelmed especially during the night. Peter has said he has not felt suicidal but can become so 'dark grey' in his mind and utter hopelessness.	A 'crisis plan' needs to drawn up where he and others involved will know what to do in times like these. First need to arrange who is willing to take a telephone in the middle of the night and call round if needed. Enquire what help organisations Peter can turn to for help in immediate instances. Care-coordinator will draw up plan after discussion again with Peter.	Needs to be supported, helped and encouraged when he experiences of episodes of despairing emotions.	02/11/11	09/11/11 (1 Wk)
Personal Home Care & Hospital appointment care				

Indentified needs, goals and risk assessment.	**Plan of appropriate action and whom is responsible.**	**Aims of what is to be achieved and intention of outcome.**	**Date of start**	**Date of Review/ Assess**
Peter is having difficulties in washing himself and although he is wanting eventually do this independently he does need help. Personal hygiene is an essential part to good health to avoid complications such as pressures sores and urinary infections.	Peter needs a carer to at least (twice a week) to help him either shower or bath. Needs to contact Occupational therapist or social services for home care.	Needs a carer especially whilst he is without home adaptations. Hoping to become independent eventually. Doctor also said this is partly why he needs to build up his inner core and arm muscles.	4/11/11	04/02/12 (3 mths)
Peter occasionally has food cooked for him by a neighbour or his sister but the majority of the time has ready made meals in the microwave. Although he loves to cook he agrees that it is not practical whilst the kitchen is not adapted.	Arrange for meals on wheels to come. Needs to contact local council in Adult Services.	Needs hot nutritious meals provided for Peter, eventually he would like o be self-sufficient and cook for him self.	02/11/11	02/05/12 (6 mths)
Difficult for Peter not having a clear idea of what his daily routine is in regards to who is to visit and when. Has to make appointments and doesn't want them to clash with his daily arrangements.	Once many of the care plans have fully been organised such as home help and meals on wheels, a written timetable needs to made of Peter's daily routines. Made by care-coordinator.	Peter will be able to organise his daily schedule, knowing who is coming and when. Peter will be able to contact the appropriate people in advance if he has to make other arrangements such as appoints	04/11/11	25/11/11 (3 Wks)

Peter does not always have family or friends to accompany him when going to hospital as an outpatient to see his consultant. The hospital is far away and needs help especially as he will be there all day. Not sure what best travel arrangements Peter can use. There is a train direct but wants to know if there are cars available supplied by local council. Private taxis are too costly for Peter Harris to continually afford.	a) arrange a carer to be with Peter on days of hospital appointments. An O.T. will assess Peter's needs. b) organise car service if available. There are many options Peter can take and many with concessions. Peter agreed to speak to Citizen's Advice Bureau if his O.T. does not provide enough information.	Will not have to continually organise someone to accompany him to important appointments or transport. Eliminate further stress for him.	2/11/11	02/05/12 (6 mths)
Social & personal goals				
Indentified needs, goals and risk assessment.	**Plan of appropriate action and whom is responsible.**	**Aims of what is to be achieved and intention of outcome.**	**Date of start**	**Date of Review/ Assess**
Peter feels it would be beneficial to be part of the many organisations out there that will help Peter rebuild his life. There are spinal cord injury fellowship groups, there are sports organisations for those who are paraplegic and disabled, support groups and other charitable programmes and awareness groups.	As Peter is a keen sportsman it would be good to contact such organisations. Need to contact and collect as many organisations which Peter can later carefully consider which ones he wants to approach and become involved in. Social worker can gather many of these groups with provide referrals and register some	It would be valuable for Peter to become somehow in any of these by his own request and a chance to find good from his life changing situation and live more to the full more than thought.	-	-

	groups that may need referrals by social services. Peter also will look on the web.			
Peter, although initially apprehensive about the suggestion for a day care centre he feels it could be a step in the right direction. Meeting people and sharing their experiences along with doing pursuits such as photography, art classes and computers maybe something Peter will greatly benefit from. There are also swimming groups.	There is a day centre called The Balfor Centre for the physically disabled which is worthwhile contacting and arranging a visit. Peter can decide when he wants to go and how long. Occupational therapist will make an assessment.	Help to resolve isolation issues and remain active. Even if Peter attends just once a week it would be a step forward.	2/11/11	2/05/12 (6 Mths)
Peter has expressed that eventually he would like to drive again. He feels frustrated at the constant arranging transport and people to assist him.	Peter at this stage wants to make enquiries only as he still feels he is not ready to drive but wants to eventually. Peter does however plans to apply for Blue Badge by contacting his local council.	Adaptations would have to be made on the car but would give Peter greater freedom and independence.	-	-
Peter feels at this moment in time it is too soon for him to think about studying or learning a hobby such as woodwork, although in time he would like to do so. He would like to in the meantime to try building model cars and planes to keep busy.	It would be good for Peter to have next year college prospectus to gain a sense of what he perhaps could do. Peter said he will ring around himself and ask for the prospectus be sent to him or download it from the internet. Has found a mail order company who sell a wide range of building kits. Peter has use of internet and says he can shop easily this way.	Peter believes it would help his mind active and occupied. Needs to remain motivated.	-	-

Home living & funding				
Indentified needs, goals and risk assessment.	**Plan of appropriate action and whom is responsible.**	**Aims of what is to be achieved and intention of outcome.**	**Date of start**	**Date of Review/ Assess**
Peter needs to access as many services and help from his local council that they can offer.	Register as disabled with local council. Peter said he will apply himself.	Reduced public fares on bus and helps council to provide and organise more services.	-	-
General housework such as cleaning and washing has proved problematic and stressful for Peter. There are no adaptations at present making it even more difficult for Peter to cope.	Needs someone to help for an hour and a half a day for housework tasks as well as personal care. Carer ideally should help for 1 hour in the morning and then return for ½ hour in the evening. Needs to be assessed by occupational therapist.	Help Peter become adjusted to things and eventually be able to do many of these himself in the future. Especially while there are no home adaptations he will benefit from extra given help.	2/11/11	22/02/12 (4 mths)
Peter wants to do most his food and other shopping on the internet but does occasionally need some items. Peter enjoys reading and hopes to make use of his local library more.	Need to arrange for a carer to go shopping or library occasionally. His occupational therapist can help assess these needs.	Build and improve Peter's quality of life.	2/11/11	22/02/12 (4 mths)
Is unsure whether to live in present home or move. Peter feels insecure about living on a	Needs to speech to someone about what would be the best option. He also needs	Peter needs a clear knowledge what best housing option to take. If he can	2/11/11	16/11/11

third floor flat reliant on a lift and risks of fire. Furthermore there is a step at the main entrance. He feels he should ideally move to better accessible accommodation and soon but feels at the same time far too stressful to move and would need someone to help him. He cannot make a decision until he knows and giving him more worry.	advice what government assistance he could receive, especially as his sister half owns the flat and does not know if she is happy about changing plans. An occupational therapist.	get better access in or out it will help him to be less isolated and insular.		(2 Wks)
When a decision has been made in regards to housing, extensive home adaptations need to be made throughout the home. Areas which Peter has highlighted are; widened door frames, lowered kitchen work tops and bathroom basin, hand rails, emergency cord by his bed, bath/shower adaptations and lowered light switches.	An evaluation made by an occupational therapist needs to be done as soon as Peter decides his next step of accommodation. Secondly he needs to contact Adult Services about being assessed of how much grant money he will be eligible for.	Peter needs to live in a secure home with full adaptations made for him so he lives as self-sufficient and dignified as possible,	2/11/11	30/11/11 (4 Wks)

Important contact numbers of friends family who provide support or care.			
Suzanne & Ian Barnes	Sister & brother-in-law	7 Colebrook Way, Hatfield, Herts. 01992 440 791 / 07940 112 067	Visits regularly, taking care of correspondence and paperwork. Is able to sometimes take Peter to hospital appointments. Can be contacted 24 hours.
Cecil Albury	Neighbour	19 Northumberland Hse.	Friend. Retired to he is often available and will help with light shopping. When he is in he can help Peter down a step at

		0208 371 5540	building entrance in the wheelchair.
Rose & Alan Gott	Neighbours	4 Northumberland Hse 0208 371 2048	Couple still work so not always available but sometimes cooks an evening meal for Peter and can contacted 24 hours and be a help if they can.

Important contact numbers of care services and organisations providing help.

Name	Address	Service	Telephone	Job duty
Jo Turner	271 High Road, N2 5JB	Social Services	0208 886 2055	Social Worker
Elise Kenworthy	271 High Road, N2 5JB	Social Services	0208 886 3127	Occupational Therapist
John Oakley	Aldrich Hospital. BD5 9LL	NHS	01725 882 333	Rehabilitation Nursing Team
Mary Murphy	Granville Practice, N3 1BZ	NHS	07790 440 271	District Nurse
Dr. R.Godwin	Aldrich Hospital, BD5 9LL	NHS	01725 882 333	Consultant
Dr. P. Sherman	Granville Practice, N3 1BZ	NHS	08444 33 91 70	G.P.

Kris Paxman	88 Watling Street, B21 9UB	Spinal Cord Trust	01450 378 221	Volunteer Worker

I give permission for the information provided in my Care Plan to be issued to anyone relevant to my care and those appropriate to have access should there be an emergency: ☒ Yes ☐ No

If NO, please specify what restrictions you wish to have:

I have recieved a copy of this care plan: ☒ Yes ☐ No Dated on the: 4th November 2011

I understand and agree with my Care Plan and able to sign: ☒ Yes ☐ No

If NO, it needs to be signed by someone acting on behalf: _____

Service user signature	Care-coordinator signature	Line manager's signature