Personal Information

NAME First Name: Surname Other Names: Title: Preferred Name: NHS No: MALE FEMALE	**ADDRESS** Address: Contact Number:
PERSONAL INFORMATION Date of Birth: Religion: Date package commenced:	**GP DETAILS** GP Name: Surgery: Telephone Number:
NEXT OF KIN 1 Name Relationship to client: Telephone Number: Alternative Number:	**NEXT OF KIN 2** Name: Relationship to client: Address: Telephone Number: Alternative Number:
Dependency score at assessment - (To be completed at the end)	
Medical History/Diagnosed Conditions: (Give brief description of diagnosed condition)	

Weekly Schedule of Times and Level of Staffing

MONDAY	**TUESDAY**
WEDNESDAY	**THURSDAY**
FRIDAY	**SATURDAY**

SUNDAY	IMPORTANT INFORMATION

Social support *Do you require assistance with the following, if yes please provide details*		
▢	Housework *(e.g laundry, cleaning)*	
▢	Keeping Occupied	
▢	Household Shopping	
▢	Keeping Appointments	
▢	Doing Paperwork	
▢	Other (*please specify)*	

Important Information/Network
(eg: Dietician, GP,)

Partnership and other professionals			
NAME	PROFESSION	ADDRESS	CONTACT NUMBER

Access to clients property **Clear guidance for accessing client's property**
Clear guidance for entering property in an emergency

Family/Neighbour / further emergency contact details			
NAME	RELATION	ADDRESS	CONTACT NUMBER

Information About You
Overview of Your Support Plan

Who I am Service User Representative ▢ (*reason i.e capacity*)
I

Personal Care - *Do you require assistance with the following, if yes provide details*		
▢	Dressing/Undressing	

▢	Washing hands & face	
▢	Washing whole body	
▢	Staying comfortable *(e.g in bed, chair)*	
▢	Do you have a perfume/aftershave you prefer	
▢	Shaving (Electric Shaver Only)	
▢	Hair washing	
▢	Hair cuts/styles	

Mobility - ***Do you require assistance with the following, if yes provide details***				
▢	Moving around the home			
▢	Mobility aids and Transfers			
▢	Getting out & about			

▢	Using Transport			
▢	Sitting to standing			
▢	Repositioning in bed			
▢	Have you had recent falls ▢ Yes No ▢	If yes a falls risk assessment is required		
	Moving and Handling Risk Assessment	▢ Yes ▢ No		

Communicating -*Do you require assistance with the following, if yes provide details*		
▢ ▢	Cognitive Baseline (*orientated to time/place/person etc)* Sensory Impaired (*Blind, deaf,wears glassess)*	
▢	Communicates verbally	
▢	Non Verbal communication List the assisted technology the service user has (*include on equipment log*)	

Elimination *Do you require assistance with the following, if yes provide details*		
▢ ▢ ▢ ▢	Fully Continent Incontinent Bowel Bladder	
▢ ▢	catheter Supra pubic	
▢	**Monitor Daily Output** **(***clinical review required)*	N/A

Breathing *(Breathlessness, Medical Condition,equipment)*		
▢	**No known complication**	
▢	**diagnosed condition**	
▢	**Tracheostomy** **size** **make**	
▢	**Ventilator** **model**	
▢ ▢	**Suction** **Oral**	

▢	**Naso pharyngeal**	
▢	**Tracheal**	

MEDICATION DETAILS

Does the service user take medication ▢ Yes No ▢
Is the service user able to self medicate? ▢ Yes No ▢

SUPPORT REQUIRED WITH MEDICATION: (In line with medication procedure)

Level of support

▢ - Level 1 General Support
▢ - Level 2 Administering Medication
▢ - Level 3 Administering Medication by specialised technique

Medication Risk Assessment Required ▢ Yes No ▢

(If no) - ***Are there any Home Remedies and Holistic Therapies, Topical Creams?***

List all Home Remedies and Holistic Therapies, Topical Creams should be listed prescribed and unprescribed.

DATE	MEDICATION & DOSE	Prescribed /Non Prescribed P / NP	ROUTE	FREQUENCY TAKEN

** If any of the above have been prescribed a full Medication Risk Assessment is required				

Dietary needs		
▢	**No known dietary needs**	
▢ ▢ ▢ ▢	**Gastrostomy (PEG)** **pump (*Model)*** **bolus** **nil by mouth**	
▢	**soft diet** **Choking Hazard** ▢ Yes No ▢	***If yes a risk assessment is required***
▢	**assistance with feeding**	
▢	**cultural diet**	
▢	**Monitor Daily Intake (***clinical review required)*	

Maintaining a safe environment (*in addition to the environmental risk assessment)*		
▢	**No assistance in place**	
▢ ▢ ▢ ▢	**Bed rails** **key safe** **intercom** **lap strap**	
▢	**safety mat/pressure pads**	
▢	**night monitors**	
▢	**Video system**	
▢	**CCTV**	
▢	**Equipment (list all equipment used to support client)**	**An equipment log is required for each item giving details of model, last maintenance and maintenance frequency.**
** A Equipment mitigation risk assessment to be completed		

Sleeping (*statement*) ***(Times, Problems, Medication, Aids Required)***

Financial Support (Bill paying, Financial Support, Access)
Is financial assistance required by Cordant Care? ▢ Yes No ▢
**** A financial risk assessment required -** ▢ Yes No ▢

Additional information (*any other information to be documented)*

The service user (or their delegated representative) has read and understood this Care Needs Assessment and consents to the care detailed within this Care Needs Assessment and associated Risk Assessments. The service user also consents for this Care Needs Assessment to be made available for inspection by the Care Quality Commission or their care funder as part of their audit process.

Service User (or their delegated representative) : _____

Signed: _____ Date : _____

Office Only

Assessment Completed by :_____

Job title _____ Signed: _____