* Name
* Preferred Name
* Address
* Date of birth
* Phone number
* NHS Number

Non-complex support plan

* Are there any know allergies?
  + Allergies:
* Is there a DNACPR or Respect form in place?
  + (If yes: )Location of the forms:
* Does the client have any Power of Attorney or Court of Protection Authorisation?
* Has the client got an impairment of the mind or brain which impacts on their ability to make decisions?
* Can the client sign his own care plan?
  + (If not) Who does it?
  + Care Preference
    - I prefer my carer to be
      * Male/Female/No preference
    - I prefer my carer to wear
      * Uniform/No preference
  + All about the client
    - About me: (including relevant history, who and what is important to me and my interests and hobbies)
      * Ex: I have lived in Rugeley most of my life. I was married to X, however he is in a nursing home currently. I have one daughter and one son who visit often. I like the television and the newspaper and I also like my family visiting
    - My medical condition(s):
      * Ex: I was admitted into hospital due to generally unwell and being diagnosed with a chest infection. I am currently nursed in bed until therapy visit and will require carers to monitor my skin integrity and report any concerns to the district nursing team. I am also doubly incontinent and will require carers to assist with my continence care. My past medical history is prolapse of the bowels, which they have informed me there is no treatment for this now. I am also type 2 diabetic which is controlled with medication and diet. I will need carers to administer medication for me
    - Outcomes and what I would like to achieve or my end of life care wishes?
  + Support Need
    - Morning
      * Every Day
    - Lunch
      * Every Day
    - Tea
      * Every Day
    - Bed
      * Every Day
    - Sit
      * None
    - Live in
      * No live in
    - Pop in night
      * No pop in night
  + I need support with the following:
    - Medication
    - Personal care and elimination
    - Skin monitoring
    - Moving and handling
    - Falls
    - Nutrition and hydration
  + Are there any risks presented in relation to medication? (i.e. client confused or trying to take medication without following the prescribing instructions?
    - Yes/No
  + Skin integrity
    - Skin integrity assessment
      * Thin and fragile skin
      * Incontinent of urine and/or faeces
    - Skin integrity risk management
      * Risk identified – high risk of my skin breaking down due to reduced/slow mobility
  + Moving and Handling
    - Is moving and handling equipment used?
      * Yes/No
    - Equipment in place:
      * Hoist (Electric)
      * Walking frame
      * Electric Profiling Bed
      * If Other, please state: commode
      * Are there any risks associated with Moving and Handling equipment?
  + Falls Risk
    - Low/Medium/High
      * Risk of falling when being transferred, due to limitations and reduced mobility
  + Nutrition and Hydration
    - I have a specialist diet?
      * Yes/No
    - Information about my specialist diet: (include information from dietician)
      * I am diabetic – which is controlled with medication and diet
  + Environmental Risk Assessment
    - No environmental risks identified/hoarding disorder
  + Is there any additional information not detailed on this plan?
  + Completed By:
  + Print name
  + Position
  + Date

Key contacts form

* Next of Kin Contacts
  + Name
  + Type: Daughter, Sister etc.
  + Emergency Contact? Yes/No
  + Phone number:
* Medical Contacts:
  + Name: Dr Smith
  + Type: GP
  + Contact Details
    - GP Phone Number:
    - GP Address:
    - GP Postcode:
* Additional Useful Contacts

Medication Change Request Form

* Date actioned
* Actioned by
* Name on label
* Date on label
* Instruction of administrating medication
* Frequency
* Dose
* Expiry date