

IPSWICH AND EAST SUFFOLK SHARED CARE AND SUPPORT PLAN

This Shared Care Plan is to be completed by integrated teams e.g. the Crisis Action Team (CAT), Integrated Neighbourhood Teams (INT) and Multidisciplinary Teams (MDT) etc. It is to be used to identify situations and actions in relation to managing urgent or planned care interventions. There is also a Living Well Care Plan within to help support people to keep well by providing advice and sign-posting. The document should remain in the person's home.

PATIENT INFORMATION






Patient Name:	Primary Diagnosis/Relevant Past Medical History:
Date of Birth:	
NHS Number:	
Carefirst 6 ID:	
Address:	Social Care Support Plan Summary:
Postcode:	
☎ H:	☎ M:
Next of Kin/Family Carer Name:	Next of Kin/Family Carer Contacts
Address:	☎ H:
	☎ M:
Named Accountable GP & Practice:	Care Coordinator name & contact:

OTHER NAMED PROFESSIONALS INVOLVED IN PATIENT'S CARE:

Designation	Name	Organisation	Telephone	Frequency of contact
Community Matron				
District Nurse				
Physiotherapist				
Occupational Therapist				
Social Worker / Community Care Practitioner				
Specialist Nurse				
Other Professional				
Other Care Agencies				
Relevant Others				

RECENT ASSESSMENTS BY HEALTH & SOCIAL CARE (list relevant assessments below):

Does patient have (please tick as appropriate):

<input type="checkbox"/> Yellow Folder 	<input type="checkbox"/> Advance Care Plan 	<input type="checkbox"/> Do Not Attempt CPR 	<input type="checkbox"/> Lasting Power of Attorney 	<input type="checkbox"/> Deputyship 
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(A summary of urgent and planned care actions to be recorded below for sharing key information with other agencies involved)

Date:

Sign and print:

Situation:	Action:		
Situation:	Action:		
Situation:	Action:		

WHAT WOULD YOU DESCRIBE AS YOUR 'NORMAL' LEVELS OF ACTIVITY (a summary of normal levels of activity in areas such as communication, social activities, breathing, eating and drinking, elimination, washing and dressing, mobilisation including equipment, sleeping. In addition identify what help you require and by whom)




GOALS (eg health, social and maintaining wellbeing etc)

Category	Objective & reason	From	Action plans	To	Date of outcome	Importance (score from 1-10)

Please contact your GP or care coordinator if any of this information is incorrect or out of date.
Please share this plan with your carers so that they are aware of your needs and choices.

LIVING WELL CARE PLAN (HOW YOU CAN KEEP WELL)

Care Coordinator to complete section below with the patient. Identify how to keep well and what to do if things start to deteriorate or if the person becomes unwell.

	<ul style="list-style-type: none"> • I'm feeling well today and am happy with the current level of support I'm getting 	HOW CAN I KEEP WELL? _____ _____ _____ _____ _____ Contact 1: _____ Contact 2: _____
	<ul style="list-style-type: none"> • I don't seem to be managing very well, to be honest I'm struggling a bit • I'm feeling increasingly out of sorts and unwell 	WHAT SHOULD I DO? _____ _____ _____ _____ _____ Contact 1: _____ Contact 2: _____
	<ul style="list-style-type: none"> • I am feeling very unwell • There is no one to help and support me and I am unable to cope 	WHAT SHOULD I DO? _____ _____ _____ _____ _____ Contact 1: _____ Contact 2: _____

SIGNATORIES		
Patient Signature*:	Print Name:	Date:
Named Accountable GP Signature:	Print Name:	Date:
Integrated Care Coordinator Signature:	Print Name:	Date:

I am happy for my medical record to be shared with other healthcare professionals that care for me	Yes / No
I am happy for you to see the notes that other healthcare professionals may make on my record	Yes / No

***Patient signature gives consent to assess and confirms that information within the Care and Support Plan is correct. It also consents to the sharing of information within the Multi-Disciplinary Team and the sharing of the clinical record with other healthcare professionals who may care for the patient.**