IPSWICH AND EAST SUFFOLK SHARED CARE AND SUPPORT PLAN – GUIDANCE v2

The Shared Care and Support Plan is to be completed by integrated teams e.g. the Crisis Action Team (CAT), Integrated Neighbourhood Teams (INT) and Multidisciplinary Teams (MDT) etc. Initial completion is by the Care Coordinator (the health or social care professional who is nominated as the lead in care delivery). 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 attached to help support people to keep well by providing advice and sign-posting. The document should remain in the patients/customers home.

Introduction
This guidance document is designed to assist the Care Coordinator to complete the Shared Care and Support Plan (SCSP) The SCSP is designed to be a patient/customer held document and should always be completed with both parties and/or their carer present.

Patient Information
This section must be completed in full. Those with access to SystemOne may be able to print out a pre-populated version when they initially receive the referral prior to visiting. However details should always be verified with the patient/customer and/or their carer to ensure accuracy. Care should be taken when discussing Primary Diagnosis/Relevant Past Medical History.

Other Named Professionals Involved in Patients/Customers Care
Check with the Patient and/or their Carer the details of all those involved in their care. Complete the form so that those who potentially see the Patient/Carer in the future are aware of the breadth of the multidisciplinary team.

Recent Assessments by Health and Social Care
This may be pre-populated by SystemOne or may be completed by the Care Coordinator. You do not need to add every assessment, just those deemed of relevance to the Patients/Customers current situation. Ensure that the boxes are ticked if appropriate if the Patient/Customer has a Yellow Folder, Advanced Care Plan, Lasting Power of Attorney, Deputyship or if they have formally deemed as Not for CPR. Care should be taken when discussing this section.

Shared Care and Support Plan
Summarise the situation the Patient/Customer is in and the actions being taken to mitigate (as many sections as necessary). Also identify the agencies to be involved in managing the situation and the required interventions. The Care Coordinator should date, sign and print beside the regime. The Patient/Customer and/or their Carer must be involved in this process.

What would you describe as 'your' normal levels of activity?
The Care Coordinator needs to take the Patient/Customer and/or their Carer through their normal levels of activity to ensure that goals set are realistic/achievable. As a trigger the following may be discussed. These are communication, social activities, breathing, eating and drinking, elimination, washing and dressing, mobilisation, equipment used, sleeping. This list is not exhaustive. There may be other levels of need identified. Health and social care professionals should have the requisite skills to be able to complete this section.

Goals
Based on the situation and the normal levels of activity the Care Coordinator sets a list of goals with the Patient/Customer and/or their Carer. They categorise the goal e.g. Social, Health, Well-Being, Self-Care etc. Objectives and reasons are identified with actions to be taken for a specific period of time. A date should be set for achieving the outcome. A scoring system should be completed based on the importance of achieving the goal.

Medication
SystemOne can pre-populate this section. However if preferred a GP printout of medications can be attached. The Care Coordinator should ensure that this is current during the period of intervention.

Allergies
This section will also be pre-populated by SystemOne, however as with medications the Care Coordinator should check with the Patient/Customer and/or their Carer.

Where to get help
This section should be completed by the Care Coordinator so the patient may be able to easily access information regarding obtaining information.

Living Well Care Plan
This part of the document is designed to assist the Patient/Customer and/or their Carer in how to keep well and what to do if things start to deteriorate or if they become unwell. This will assist in promoting self-care and on-going well-being in order to mitigate against a future crisis which might result in the Patient/Customer needing to be admitted into hospital. Patients/Customers invariably do best if they remain within their own homes (if possible) as hospitalisation can result in a 'deconditioned Patient/Customer). The Care Coordinator should complete it in partnership with the Patient/Customer and/or their Carer to ensure concordance.

Signatories & Consent
It is important to make sure that the document is signed by all 3 parties mentioned to record that consent has been given for the appropriate people to view the document. If the document is being recorded electronically on SystmOne, the patient must also record informed consent for sharing their record out and in by answering the Yes/No questions below the signatures.