**P14 DMH**

**Personal Support Plan**

**Name:**

|  |
| --- |
| Picture / Photo |

**Date Personal Support Plan created: DD.MM.YYYY**

**By:**

**Photo confirmed as true likeness: DD.MM.YYYY**

**By:**

**Please ensure the document is “saved as” with the date you reviewed and /or updated it when using electronic versions.**

Version 2 – 28.05.19

**Index**

Section 1 **Personal and health information**

Section 2 **One page profile**

Section 3 **Person centred support summary and protocols**

Section 4 **Relevant and current assessments and strategies**

e.g. Risk assessments, epilepsy rescue protocol, positive handling plan, FACE profile

Section 5 **Consultation record** - including notes of most recent review

**Appendices**

Appendix 1 **Protocol recording sheet**

Appendix 2 **Example protocols**

Appendix 3 **Example review notes recording form**

Appendix 4 **Contact information sheets**

Appendix 5 **Example consultation recording sheets**

Appendix 6 **Getting to know you! – Pre-admission assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Review record** | | | | |
|  | **Date** | **Name** | **Please note changes** | **Next review** |
| Created | **00.00.0000** |  |  | **00.00.0000** |
| Reviewed / Updated |  |  |  |  |
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| Reviewed / Updated |  |  |  |  |
| Reviewed / Updated |  |  |  |  |

**Contact information sheets stored at:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Personal Information** | | | **D.O.B.** |  |
| **Full name:** |  | | **NHS Number:** |  |
| **Preferred Name:** |  | | **IAS Number:** |  |
| **Address:** |  | | **NI Number:** |  |
| **Room Number:** |  |
| **Key Issued?** | Y / N |
| **CQC Unique ID:** |  |
| **Telephone:** |  | | **Date this service started:** |  |
| **Mobile:** |  | | **How this service is funded:** Local Authority, CHC, Independent. |  |
| **Email:** |  | |
| **Religious / Cultural choices:** | |  | | |
| **Communication / Language:** | |  | | |

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| **Next of Kin** | | | |
| **Name:** |  | **Tel Number:** |  |
| **Relationship:** |  | **Mobile:** |  |
| **Address:** |  | | |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Health Information** | | | | | | | |
| **GP Details & Contact Number:** | |  | | | | | |
| **Any Known Allergies:** | |  | | | | | |
| **Health needs / Conditions**  See also Hospital Passport and Health Record if applicable | |  | | | | | |
| **Capacity & Statutory Provision** | | | | | | | |
| **Capacity:**  **Please state any specific relevant information in regards to decision making and capacity:**  *For consent and decision making issues follow the mental capacity guidelines.* | | | | |  | | |
| **DoLs/DoL:** | N/A | |  | **DNACPR:** | | Offered |  |
| Yes | |  | Accepted / Declined |  |
| Submission Date | |  | Comment: | |
| Renewal Date | |  |
| **Person Centred advanced care statement:** | Offered | |  | **Court of Protection:** | | Yes / No |  |
| **(PCACS)** | Comment: | | | **Enduring / Lasting Power of Attorney** | | E/LPA – Health & Well Being | Start Date: |
| Administrator: |
| E/LPA – Financial | Start Date: |
| Administrator: |

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| --- | --- | --- | --- |
| **Professional Contacts** | | | |
| **Service** | **Name of Service** | **Contact Name** | **Telephone** |
| **Social Worker** |  |  |  |
| **Community LD Nurse** |  |  |  |
| **Link Worker** |  |  |  |
| **Day Service** |  |  |  |
| **Accommodation Service** |  |  |  |
| **Respite Service** |  |  |  |
| **Other Care Agencies** |  |  |  |
| **Advocate** |  |  |  |
| **Work Placement / Employment** |  |  |  |
| **Opticians:** |  |  |  |
| **Dietician:** |  |  |  |
| **District Nurse:** |  |  |  |

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**One Page profile: Insert Name**

|  |  |
| --- | --- |
| **Insert photo** | **What others like and admire about me** |
|  |

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| --- |
| **What’s important to me** |
|  |

|  |
| --- |
| **How best to support me** |
|  |

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| Summary of person centred support needs | | | |
| If any support or prompting is needed, a protocol is required to  clearly identify how this will be provided | | | |
|  | **No support needed** | **Some support or prompting needed** | **Please see protocol number** |
| Communication |  |  |  |
| Choosing where to live |  |  |  |
| Staffing |  |  |  |
| Medication |  |  |  |
| Sight and hearing |  |  |  |
| Health |  |  |  |
| Mobility |  |  |  |
| Pain management |  |  |  |
| Accessing the community |  |  |  |
| Going out |  |  |  |
| Money / finances / budgeting |  |  |  |
| Meal planning and cooking |  |  |  |
| Eating / nutrition |  |  |  |
| Drinking / hydration |  |  |  |
| Continence |  |  |  |
| Menstruation |  |  |  |
| Personal care support |  |  |  |
| Housekeeping |  |  |  |
| Personal safety |  |  |  |
| Environment |  |  |  |
| Getting up and going to bed |  |  |  |
| Morning |  |  |  |
| Daytime |  |  |  |
| Evening |  |  |  |
| Weekend |  |  |  |
| Night time |  |  |  |
| Fitness |  |  |  |
| Relationships |  |  |  |
| Activities and hobbies |  |  |  |
| Sexuality |  |  |  |
| Skincare |  |  |  |
| Family |  |  |  |
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| **Index of relevant and current assessments and strategies** | | | |
| **Document** | **Date added** | **Date removed** | **Initials** |
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