Professional Record Standards Body

Digital care and support plan standard

Information models – v1.1

Better records
for better care

SECTION: **ABOUT ME**

This section is **REQUIRED** ***CARDINALITY:*** **0 - 1**

ENTRY: **About me.**

This acts as a container that holds all of the elements for each instance of an about me entry. There will be **0 to many** instance of an entry. **For each instance of that entry there will be the following elements:**

ELEMENTS:

Name	Description	Cardinality	MRO	Values
About me	This is a record of the things that an individual feels it is important to communicate about their needs, strengths, values and preferences, etc to others providing support and care.	0 TO 1	Required	Free text. The record could be structured under subheadings such as my abilities, assets, strengths, likes and dislikes, challenges, things that have worked well in the past, faith or spiritual beliefs of the person in relation to their care. This may retrieve information from other parts of the care record. Content may vary between use cases.
Supported to write this by	Where relevant, this is a record of name, relationship/role and contact details of the person who supported the individual to write this section e.g. carer, family member, advocate, professional.	0 TO 1	Required	Free text
Date	This is a record of the date that this information was last updated.	0 TO 1	Required	Date/time.

SECTION: **CARE AND SUPPORT PLAN**

DESCRIPTION: **This records the decisions reached during a conversation between the individual and a health and care professional about future plans and also records progress and changes made since the last planning session.**

This section is **REQUIRED** ***CARDINALITY:*** **0 - 1**

ENTRY: **Care and support plan.**

This acts as a container that holds all of the elements for each instance of a care and support plan entry. There will be **0 to 1 ONLY** instance of an entry. **For each instance of that entry there will be the following elements:**

ELEMENTS:

Name	Description	Cardinality	MRO	Values
Strengths	Any strengths and assets the	0 TO MANY	Required	Free text.

	individual has that relate to their goals and hopes about their health and well-being.			
Needs, concerns or health problems	Needs, concerns or health problems an individual has that relate to their health and well-being.	0 TO MANY	Required	Free text. May be SNOMED CT coded - values may be linked to problems and diagnoses from individual's care record to avoid duplication.
Goals and hopes	The overall goals, hopes, aims or targets that the individual has. Anything they want to achieve that relates to their future health and wellbeing. Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the individual.	0 TO MANY	Required	Free text. May be SNOMED CT coded Coded status of goal: Achieved, partially achieved, not achieved, Not applicable
Actions and activities	Actions or activities the individual or others plan to take to achieve the individual's goals and the resources required to do this. For each action the following may be identified: a) Stage goal – a specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional b) What – what the action is and how it is to be carried out? c) Who – name and designation (e.g. person, carer, GP, OT, etc.) of the person, or a team, carrying out the proposed action, and, if relevant where action should take place d) When – planned date, time, or interval, as relevant e) Suggested strategies for potential problems	0 TO MANY	Required	Free text. May be SNOMED CT coded Coded status of action: Not Started, Started, Complete, Not applicable Associated sub-headings for each action are optional and decided locally.

	f) Status – Not started, Started, Completed, Not applicable g) Confidence – how confident the person feels to carry it out h) Outcome – the outcome of the stage goal i) Date when action/activity record was last updated j) Review date – when the stage goal and action need to be reviewed			
Outcomes	Outcomes of each of the individual's goals, aims and targets. Includes comments recorded by the individual, date and status: fully achieved, partially achieved, not achieved, on-going, no longer applicable.	0 TO MANY	Required	Free text May be SNOMED CT coded. Coded text: fully achieved, partially achieved, not achieved, on-going, no longer applicable.
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	0 TO 1	Required	A record of the agreement of the decisions made.
Planned review date/interval	This is the date/interval when this information will next be reviewed.	0 TO 1	Required	Date/Time
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0 TO 1	Required	Free text. Usually expressed as name X, designation Y
Care funding source	A reference to the funding source and any conditions or limitations associated.	0 TO 1	Optional	Free text.
Other care planning documents	Reference other care planning documents, including the type, location and date. This may include condition-specific plans, advance care plans, end of life care plan, etc.	0 TO MANY	Optional	Free text. May include hyperlink
Person completing record	This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details	0 TO MANY	Required	Free text. Name, Role, Grade, Specialty, Organisation, Professional identifier, Date and time completed, Contact details
Date this plan was	This is a record of the date	0 TO 1	Required	Date/time

last updated	that this care and support plan was last updated.			

SECTION: **CONTINGENCY PLAN**

DESCRIPTION: **These are the things to do and people to contact should an individual's health or other circumstances get worse.**

This section is **REQUIRED** ***CARDINALITY:*** **0 - 1**

ENTRY: **Contingency plan.**

This acts as a container that holds all of the elements for each instance of a contingency plan entry. There will be **0 to Many** instances of an entry. **For each instance of that entry there will be the following elements:**

ELEMENTS:

Name	Description	Cardinality	MRO	Values
Contingency plan name	Name of the contingency plan – what condition or circumstances it is addressing.	0 TO 1	Required	Text May be SNOMED CT coded.
Trigger factors	Signs to watch out for that may indicate a significant change in health or other circumstances.	0 TO MANY	Required	Free text. A statement of trigger factors.
What should happen	To record guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the individual.	0 TO MANY	Required	Free text. A statement of suggested actions. Usually expressed as: in the event of X do Y.
Who should be contacted	Who should be contacted in the event of significant problems or deterioration in health or wellbeing including. E.g. name, relationship and contact details of persons.	0 TO MANY	Required	Free text. This may be obtained from the record of relevant contacts elsewhere in the person's record.
Anticipatory medicines/ equipment	Medicines or equipment available that may be required in specific situations and their location.	0 TO MANY	Required	Free text. A statement regarding the availability or location of the anticipatory medicines/equipment.
Planned review date/interval	This is the date/interval when this contingency plan will next be reviewed.	0 TO 1	Required	Date/Time.
Person completing record	This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional	0 TO 1	Required	Free text. Name, Role, Grade, Specialty, Organisation, Professional identifier, Date and time completed, Contact details

	identifier, date and time completed, contact details			
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0 TO 1	Required	Free text. Usually expressed as name X, designation Y
Date this plan was last updated	This is a record of the date that this contingency plan was last updated.	0 TO 1	Required	Date/time
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.	0 TO 1	Required	Free text

SECTION: **ADDITIONAL SUPPORTING PLAN**

DESCRIPTION: *An embedded record of any additional care plans which the individual and/or care professional consider should be shared with others providing care and support.*

This section is **OPTIONAL** ***CARDINALITY:*** **0 - 1**

ENTRY: **Additional supporting plan.**

This acts as a container that holds all of the elements for each instance of a contingency plan entry. There will be **0 to MANY** instances of an entry. **For each instance of that entry there will be the following elements:**

ELEMENTS:

Name	Description	Cardinality	MRO	Values
Additional supporting plan name	The name of the particular additional supporting plan, e.g. dieticians plan, wound management plan, discharge management plan.	0 TO 1	Required	Free text.
Additional supporting plan content	This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing care and support. It should be structured as recommended for the care and support plan and if contains additional detail, it may be referenced here.	0 TO 1	Required	May be an embedded document or link to the additional plan content. Free text. May be structured in different ways, eg tables, diagrams, images.
Person completing record	This is the person contributing to the care and support plan. Should include their name, role, grade, specialty, organisation, professional identifier, date and time completed, contact details	0 TO 1	Required	Free text. Name, Role, Grade, Specialty, Organisation, Professional identifier, Date and time completed, Contact details

Planned review date/interval	This is the date/interval when this information will next be reviewed.	0 TO 1	Required	Date/Time.
Responsibility for review	This is a record of who has responsibility for arranging review of this information. Should include their name, role and contact details.	0 TO 1	Required	Free text. Usually expressed as name X, designation Y
Date this plan was last updated	This is a record of the date that this information was last updated.	0 TO 1	Required	Date/time