Professional Record Standards Body

Better records for better care

DIGITAL CARE AND SUPPORT PLAN STANDARD

EXAMPLE USE CASES

Example use cases

Example use cases are provided below to illustrate how the headings can be used to accommodate different styles of plans and can be used by people with different health and wellbeing strengths, needs and problems. They illustrate use by people with multiple long-term conditions, mental health issues, learning disabilities and complex health conditions. Examples of how the about me, contingency plan and emergency plan headings can be used are also provided.

Please note the examples provided are strictly for illustration purposes (i.e. to show how information can be recorded using the headings in different care settings) and are not intended as exemplars of the way in which care plans should be ordered and sequenced.

Each example comprises two stages that illustrate the on-going development of the digital care and support plan, with multi-disciplinary team or multiple care provider input. The first stage is initiation – when a care and support plan is first created. This action may include referrals to other professionals. The second stage is a later point in time when another professional adds information to the plan with onward actions. Within this document, the second stage is indicated in a yellow shade. '*Myself*' in each example refers to the person the care and support plan is owned by, and should include their name and contact details.

7.1. Example 1

Patient demographics	
Patient name	Ms Jane Doe
Date of birth	01/01/1960
Gender	Female
NHS number	123456789
Hospital ID	HN98765
Patient address	46 Birch Close AG2 6SL
Patient email address	
Patient telephone number.	077 7777 777
GP Practice details	
GP practice identifier	ASDF7789
GP name	Dr Joe Collins
GP details	U Health Centre, 12 High Road, AG1 2RD, (01234) 956412

Relevant contacts		
Name	*Relationship / role*	*Contact details*
Tom Smith	Care-coordinator	tom.smith5@nhs.net
Richard Doe	Husband	077 899 888
Lisa Lowe	Daughter	079 999 999
Tom Robbins	Physiotherapist	t.robbins@nhs.net
Dr Jane Collins	COPD specialist	jane.Collins2@nhs.net
Janet Moss	Pharmacist	j.moss@nhs.net
Sandra Laing	Occupational Therapist	s.laing@nhs.net

Social context	
Services and care	Main Hospital NHS, 30 High Rd, AG1 8SD
	Community Health NHS, 56 High Rd, AG1 3JL
	Specialist service NHS, 72 Round Lane, AG2 3YA

The above information with any additional records (e.g. diagnoses, investigation results) would also be used to inform care and support planning.

About me	**Supported to write this by**	**Date**
I am 78 and I live with my husband. I enjoy looking after my grandchildren. I would like to do more with them but get pains from arthritis. I also have diabetes and COPD.	Myself (Ms Jane Doe) Dr Joe Collins, GP, joe.Collins9@nhs.net	17.10.17

The care and support plan in example 1 includes two goals initially agreed between a GP and the person. One of the goals: *'to walk to the park with my grandchildren*' initially included one action for the GP to make a referral to a physiotherapist. The care and support plan illustrates how after the appointment in one month's time, the physiotherapist has agreed and added a stage goal related to the overall goal. There is also a related action as well as suggested strategies and the person has identified that on a scale of 1 to 10, their confidence is at 7 to carry out the action. When this stage goal was fully achieved, a new stage goal was agreed. At the next review, status of each action and outcomes of goals will be further updated.

This person also has an additional COPD action plan attached to the care and support plan.

Needs, concerns or health problems	Goals	Stage goal	Actions		Outcomes	Person completing record
Would like to lose weight	To fit into size 16 dress by Christmas **Importance:** 10/10		Increase walking. Cut out daily biscuits with morning and afternoon coffee. Change sugar to sweeteners in hot drinks.	**Who:** Myself **When:** Between now and Christmas **Status:** Not started **Date:** 17.10.17 **Planned review date:** 6 months		**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery
Pain in knees	To walk to the park with my grandchildren **Importance:** 10/10		Gradually increase walking distance, see physiotherapist	**Who:** Myself/ physiotherapist **When:** Over 6 months **Status:** Started **Date:** 17.10.17 **Planned review date:** 6 months	On-going	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery
		To walk to the end of the garden **Outcome:** Fully achieved	To do home exercise programme as given by the physiotherapist. 10 repeats of each exercise x2 daily	**Who:** Myself **When:** Until end of May **Suggested strategies:** Slowly increase walking distance each week		**Name:** Tom Robbins **Role:** Physiotherapist **Contact:** 020 345 6789, t.robbins@nhs.net **Organisation:** NHS Trust

		24.11.17		**Status:** Completed **Confidence:** 7/10 **Date:** 10.11.17		
		To walk to the end of the street	Continue home exercise program. 15 repeats of each exercise x3 daily	**Who:** Myself **When:** Until end of May **Date:** 24.11.17		
			Physio review	**Who:** Physiotherapist **When:** At end of May **Status:** Not started **Date:** 10.11.17 **Planned review date:** 6 months		**Name:** Tom Robbins **Role:** Physiotherapist **Contact:** 020 345 6789, t.robbins@nhs.net **Organisation:** NHS Trust

Planned review date/interval	Responsibility for review	Agreed with person	Date this plan was last updated	Last updated by
In 6 months	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery	Yes	10.11.17	**Name:** Tom Robbins **Role:** Physiotherapist **Contact:** 020 345 6789, t.robbins@nhs.net **Organisation:** NHS Trust

Other care planning documents	Date
COPD action plan	17.10.17

Contingency plan

Plan name	Trigger factors	What should happen	Who should be contacted	Anticipatory medicines/ equipment	Agreed with person	Person completing record	Date this plan was last updated	Planned review date	Responsibility for review
COPD contingency plan	Chest infection/ exacerbation COPD	Follow advice on COPD action plan. Start rescue pack if indicated.	Urgent Care Team 01915555555 or Glenpark Surgery on 019122222222	Amoxicillin 500mg tds and Prednisolone 30mg daily as per rescue pack plan	Yes	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery	17.10.17	19.04.17	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery

7.2. Example 2

Example 2 includes a care and support plan developed in agreement between GP and the person. On a separate appointment, the GP has worked with the person to add additional information to their 'about me' section on how the person takes their medication. The person felt this was important to note and communicate.

Importance of each goal, confidence of carrying out each action and suggested strategies are included in the care and support plan. Goals and actions will be updated at the next review.

A contingency plan for COPD was developed by another specialist on a previous occasion.

About me	Supported to write this by	Date
My 45 year old son died before Christmas last year and I still feel sad. I get very down at that time of year I like to be straight with people and for people to explain things properly I have breathing problems and diabetes My wife gets worried about my health	Myself	17.10.17
How I take my medication: Metformin, 500mg, For diabetes. One capsule three times daily with food Atorvastatin, 20mg for Cholesterol. At night.	Myself; Dr Joe Collins, GP, joe.Collins9@nhs.net	26.10.17

Care and support plan

Needs	Goals	Actions		Outcomes	Person completing record
Improve my breathing	Increase my activity **Importance:** 8/10	Go to the rehab group again	**Who:** GP referral **When:** In the next month **Suggested strategies:** Go just to the exercise bit of the rehab group **Status:** Not started **Confidence:** 7/10 **Date:** 17.10.17 **Planned review date:** 17.11.17		**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery
Weight issues	Lose weight **Importance:** 5/10	Halve my wine intake	**Who:** Myself **When:** 12 lbs in 3 months **Suggested strategies:** Halve wine intake to ½ a bottle at a time instead of a full bottle **Status:** Not started **Confidence:** 8/10 **Date:** 17.10.17 **Planned review date:** 17.11.17		**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery

Planned review date/interval	Responsibility for review	Date this plan was last updated	Updated by
17.11.17	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** NHS Trust	17.10.17	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery

Contingency plan

Plan name	Trigger factors	What should happen	Who should be contacted	Anticipatory medicines/ equipment	Agreed with person	Person completing record	Date this plan was last updated	Planned review date	Responsibility for review
COPD plan	Coughing and breathing worse Green phlegm	Use my rescue medication early and don't put off like last time	Liz 0777589857 if no improvement in symptoms	Rescue pack at home	Yes	**Name:** Dr Jane Collins **Role:** COPD specialist **Contact:** 020 345 6789, jane.Collins2@nhs.net **Organisation:** NHS Trust	08.08.17	In 6 months	**Name:** Dr Jane Collins **Role:** COPD specialist **Contact:** 020 345 6789, jane.Collins2@nhs.net **Organisation:** NHS Trust

7.3. Example 3

The care and support plan in example 3 was initially agreed in a care planning session six months prior to the illustrated example and had one goal related to '*getting out more*' with two actions assigned to the person themselves. During a review with the GP, the person discussed their progress and the goal was marked as fully achieved. It has now been archived from the main care and support plan view but is still accessible in the appendix. One new concern 'feeling unfit' and an associated goal were agreed by the person and their GP at the consultation.

About me	Supported to write this by	Date
I moved to the area from Cumbria I don't know anyone in the area My husband recently had a heart attack I have diabetes and heart disease	Myself	17.05.17

Care and support plan

Needs, concerns or health problems	Goals	Actions		Outcomes	Person completing record
Feeling unfit	Lose 6 lbs in weight in 6 weeks and keep it off **Importance:** 9/10	Join Slimming World	**Who:** Myself **When:** Next week **Suggested strategies: Status:** Not started **Confidence:** 7/10 **Date:** 18.11.17 **Planned review date:** 25.04.18		**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery

Appendix – archived items removed from the main care and support plan view

Needs, concerns or health problems	Goals	Actions		Outcomes	Person completing record
Feeling lonely	Getting out more **Importance:** 10/10	Look into local WI and Woman's Guild groups and join	**Who:** Myself **When:** This week **Suggested strategies:** Getting out at least 3 times a week **Status:** Completed **Confidence:** 9/10 **Date:** 17.05.17 **Planned review date:** 18.11.17	Fully achieved. 18.11.17 **Comment:** Feeling better and getting out regularly; joined local groups	**Name:** Dr Joe Collins **Role:** GP **Contact:** 020 345 6789, joe.Collins9@nhs.net **Organisation:** Surgery
		Talk to my husband about how I feel about having to be in all of the time	**Who:** Myself **When:** This week **Status:** Completed **Date:** 17.05.17 **Planned review date:** 18.11.17		

Planned review date/interval	Responsibility for review	Agreed with person	Date this plan was last updated	Updated by
In 6 months	Dr Kate Atkins, GP, NHS Trust	Yes	18.11.17	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery

7.4. Example 4

Example 4 includes an initial plan as agreed between the person and their care-coordinator during a Care Programme Approach (CPA) meeting. Several actions were followed up by the patient and these were indicated as completed. Additional actions were then added by a physiotherapist, consultant psychiatrist and a pharmacist a couple of weeks later – these all relate to what was previously agreed and now include further input from these specialists.

About me	Supported to write this by	Date
What recovery means to me? My long term goals! What I would like to achieve in 12 months' time… Return to work as a teacher, redecorate my bedroom and enjoy eating again. **What matters to me** Feeling safe, having friends and being useful **My skills, strengths and experiences that will help me achieving my goals** I am a teacher, I love children. I have been through a lot and can help them. I enjoy being creative.	Myself	11/09/2017

Care and support plan

Needs, concerns or health problems	Goals	Stage goal	Actions		Outcomes	Person completing record
Mental health	Overall goal: no symptoms Smallest improvement: feel more alert in the day. Do my breathing exercises.		1) Take medication at night 2) Work with my therapist on my abuse history and not feeling afraid. 3) Think through a COPD attack and a panic attack.	1) **Who:** Myself **Status:** Completed 2) **Who:** Myself **Status:** Completed 3) **Who:** Myself 4) **Who:** Care-coordinator	Partially achieved 29/11/2018	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** MH NHS Trust

			4) Discuss medication options and support Sadie to seek out friends 5) Set reminder of when to take medication; encourage Sadie to go out of the house regularly.	5) **Who:** Family **Date:** 11/09/2017 **Planned review date:** 11/02/2018		
Physical health	Overall goal: Less breathless because of COPD, able to exercise more. Smallest Improvement: do my breathing exercises daily rather than weekly and so feel less wheezy		1) Breathing exercises 2) Check with physiotherapist and ensure breathing exercises and physical exercises are lined up with psychology advice 3) Check with community pharmacist re drug interactions	1) **Who:** Myself 2) **Who:** Myself **Status:** Completed 3) **Who:** Care-coordinator **Date:** 11/09/2017 **Planned review date:** 11/02/2018	Partially achieved 29/11/2018	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** MH NHS Trust
			Daily breathing and physical exercise programme. 10 repeats of each exercise x2 daily	**Who:** Myself **Date:** 29/11/2017 **Planned review date:** 11/02/2018		**Name:** Tom Robbins **Role:** Physiotherapist **Contact:** 020 345 6789, t.robbins@nhs.net **Organisation:** NHS Trust

Job situation	Overall Goal: to return to school teaching next academic year. Smallest improvement: To practice lesson planning		1) Buy paper for lesson planning and plan three lessons by next month. 2) One friend to practice lesson with.	1) **Who:** Myself 2) **Who:** Friend **Date:** 11/09/2017 **Planned review date:** 11/02/2018	On-going	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** MH NHS Trust
Leisure activities	Overall goal: to go out twice a week, once on own and once with a friend Smallest improvement: to go shopping once with a friend and to stay out until the panic subsides.		1) Identify a day to go out 2) To go out for a planned two hours.	**Who:** 1) **Who:** Myself 2) **Who:** Friend **Date:** 11/09/2017 **Planned review date:** 11/02/2018	On-going	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** MH NHS Trust
Medication	Overall goal: to reduce or adjust my medication so I have fewer or no side effects, particularly heart palpitations, sweats, lethargy, breathlessness.		1) Speak with psychiatrist about side effects 2) Liaise with COPD physician and physio re side effects	1) **Who:** Myself **Status:** Completed 2) **Who:** Care-coordinator **Date:** 11/09/2017 **Planned review date:** 11/02/2018	Partially achieved 22/09/2017	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** MH NHS Trust

		Reduce lethargy caused by medication	To trial alternative medication over the next month	**Who:** Dr J Brown, Consultant Psych **When:** Starting next week **Date:** 22/09/2017 **Planned review date:** 22/10/2017		**Name:** Dr Jon Brown **Role:** Consultant Psychiatrist **Contact:** 020 345 6789, job.brown14@nhs.net **Organisation:** MH NHS Trust
			Review prescribed medications for interactions and side effects	**Who:** J Moss, Pharmacist **Date:** 28/09/2017 **Planned review date:** 28/12/2017		**Name:** Janet Moss **Role:** Pharmacist **Contact:** 020 345 6789, j.moss@nhs.net **Organisation:** Pharmacy

Planned review date/interval	Responsibility for review	Agreed with person	Date this plan was last updated	Updated by
Every 6 months	Dr J Brown, Consultant Psychiatrist	Yes	29/11/2017	**Name:** Tom Robbins **Role:** Physiotherapist **Contact:** 020 345 6789, t.robbins@nhs.net **Organisation:** NHS Trust

7.5. Example 5

Example 5 includes additional relevant information added by the person to their 'about me' section at a later date. The care and support plan includes goals initially agreed between the person and their social worker and later updated in a consultation with GP. Several actions were originally referrals to specialists and these are now completed, with associated goals now including additional actions after patient's consultation with an occupational therapist and multiple sclerosis consultant nurse specialist.

One of the initially agreed and fully achieved goals have been archived as illustrated in the care and support plan appendix section, as the care and support plan only shows currently relevant goals and actions.

Contingency plan section illustrates additional plans being added at different dates and by different professionals as they were agreed with the person.

About me	Supported to write this by	Date
My name is Jane, I am 46 years old and have secondary progressive multiple sclerosis. I was diagnosed with MS 14 years ago. I don't have relapses anymore – but do get worse when I am poorly or have an infection. My MS means I have a bad tremor in both my arms when I am trying to do something. I also find it difficult to move my legs – so need to hold on to something when walking inside the house. I need help getting into the bath and doing up buttons/ bras and putting my socks on. My mum does all the cooking and cleaning and has to help me with cutting up my food. She also has emphysema so finds it more difficult to look after me now, especially helping me in and out of the bath. I live in Hackney with my mother in a two-bedroom maisonette. I used to live on my own but moved back home five years ago. I was a hairdresser and loved going out and being sociable. I used to be a regular at the Hackney Empire. I stopped working five years ago because I couldn't cut hair anymore due to my tremor. I really miss working. I can't go out for a cup of tea because I shake all over the place and people look at me.	Myself; Stephen Robins, Social Worker, 020 345 6789, srob@msc.gov,	16/01/2017
I find going out difficult now and have to use a three wheeled walker. I get tired, but also very wobbly and have fallen over before. I go shopping once a week with my mum. Most of my friends have busy family lives so I don't see them much.	Myself	01/09/2017

Care and support plan

Needs, concerns or health problems	Goals	Stage goal	Actions		Outcomes	Person completing record
Upper limb tremor	To be able to use my hands more		Referral to OT	**Who:** Social worker **When:** 16/09/2017 **Suggested strategies: Status:** Completed **Date:** 16/09/2017 **Planned review date:** 20/02/2018	On-going	**Name:** Stephen Robins **Role:** Social Worker **Contact:** 020 345 6789, srob@msc.gov **Organisation:** Adult social care
		Be able to put on makeup	To trial strategies and adaptive equipment	**Who:** Occupational Therapist **When:** Within a month **Suggested strategies:** Use weighted cuffs Lean through elbows on table set up **Status:** Started **Date:** 28/09/2017		**Name:** Sandra Laing **Role:** Occupational Therapist **Contact:** 020 345 6789, s.laing@nhs.net **Organisation:** NHS Trust
Urinary frequency and urgency	To be able to manage my bladder better.		Referral to MS specialist nurse	**Who:** GP **When:** 10/10/2017 **Suggested strategies:** Provision of inco pads **Status:** Completed **Date:** 10/10/2017	On-going	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery

			Referral to incontinence service	**Who:** MS Consultant Nurse Specialist **Suggested strategies:** Medication review **Status:** Completed **Date:** 28/10/2017		**Name:** Olivia Smith **Role:** MS Consultant Nurse Specialist **Contact:** 020 345 6789, o.smith@nhs.net **Organisation:** NHS Trust
Mobility/ Falls	To be able to get around better		Referral to physiotherapy to review mobility	**Who:** GP **When:** 10/10/2017 **Status:** Completed **Date:** 10/10/2017	On-going	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery
			Referral to occupational therapy to review bath transfers	**Who:** GP **When:** 10/10/2017 **Status:** Completed **Date:** 10/10/2017		
Social interaction	To go out more		1) Refer to local MS support group 2) ? look into voluntary work opportunities	**Who:** Occupational Therapist/Myself **Status:** Started **Date:** 28/09/2017 **Planned review date:** 20/02/2018		**Name:** Sandra Laing **Role:** OT **Contact:** 0203456789, s.laing@nhs.net **Organisation:** NHS Trust

Appendix – archived items removed from the main care and support plan view

Needs, concerns or health problems	Goals	Actions		Outcomes	Person completing record
Carer / respite	To help my mum more.	1) Care needs assessment 2) To trial ready meals 3) Contingency plan in place for potential hospital admission (mother)	**Who:** Social Worker **Status:** Completed **Date:** 16/09/2017 **Planned review date:** 20/02/2018	Fully achieved 28/09/2017	**Name:** Stephen Robins **Role:** Social Worker **Contact:** 020 345 6789, srob@msc.gov **Organisation:** Adult social care

Additional supporting plans

Plan name	Person completing record	Planned review date/interval	Responsibility for review
MS nurse care plan	Olivia Smith, MS Nurse, 020 345 6789, o.smith@nhs.net	Every 6 months	Olivia Smith, MS Nurse

Planned review date/interval	Responsibility for review	Date this plan was last updated	Updated by
Every 6 months	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery	28.10.17	**Name:** Olivia Smith **Role:** MS Consultant Nurse Specialist **Contact:** 020 345 6789, o.smith@nhs.net **Organisation:** NHS Trust

Contingency plans

Plan name	Trigger factors	What should happen	Who should be contacted	Anticipatory medicines/ equipment	Agreed with person	Person completing record	Date this plan was last updated	Planned review date	Responsibility for review
Multiple Sclerosis	Disease relapse	Early treatment	GP (urgently)	Steroids, Prednisolone 40mg daily	Yes	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery	10/10/2017	Every 6 months	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery
UTI	Urinary tract infection	Urine sample to GP Review antibiotics Antibiotic provision	GP/ MS CNS	Nitrofurantoin 100mg 4 times daily	Yes	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery	10/10/2017	Every 6 months	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery
Hospital admission plan	Hospital admission	I am a carer of my mother. If I am admitted to hospital, please contact social worker as emergency point of contact.	Social worker		Yes	**Name:** Stephen Robins **Role:** Social Worker **Contact:** 020 345 6789, srob@msc.gov **Organisation:** Adult social care	16/09/2017	Every 6 months	**Name:** Dr Kate Atkins **Role:** GP **Contact:** 020 345 6789, k.atkins@nhs.net **Organisation:** Surgery

7.6. Example 6

Example 6 illustrates a plan for a person who is unable to make decisions about their support and includes additional legal information from their record. An initial care and support plan was agreed by their Community Learning Disability Team. The plan was later updated by Epilepsy Nurse with their action noted. The plan was further reviewed and updated by the Team, and includes an additional action as well as an update on the progress of previous actions, several of which are now marked as partially achieved.

Epilepsy contingency plan was also updated at a later point in time after initial action for the care-coordinator to liaise with epilepsy nurse.

About me	Supported to write this by	Date
My name is Andrew, but I like to be called Andy. I am 19 years old. I love going for long walks and watching music videos on YouTube. I have autism and learning disabilities. I find it difficult to cope with changes that I don't expect. I have limited communication skills. I get anxious easily and when I am anxious I will ask for things that I know make me feel safe. I don't always want these things, but I want you to help me to be less anxious. I can't always explain to you clearly what I want. I also struggle to understand some things you tell me, particularly if this involves things that are abstract, like time. When I am anxious or excited I may try to run from my support. When I run I am not aware of risks and I may run into the road, even if it is busy and a car is coming. I have epilepsy. I have complex partial seizures where I usually hold my arm over my head. I also have tonic-clonic seizures when I will fall to the floor and shake. I have buccal midazolam prescribed for it if the seizures don't stop. It is important that you have read my epilepsy support plan to know how to support me when I have a seizure.	Care-coordinator, Tom Smith, LD Nurse, tom.smith5@nhs.net	02/02/2017

Deprivation of Liberty Safeguards or equivalent	Andy is unable to make decisions about his support. Deprivation of Liberty Safeguards have been authorised to reflect his need for two to one support and that he may be prevented from leaving his home if it is felt unsafe.
Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)	His parents have power of attorney for his finances, health and welfare. This means they may consent on his behalf and should be involved in all decisions.
Legal safeguarding issues	None
Mental Health Act or equivalent status	Andy has recently been detained in a specialist learning disability hospital under Section 3 of the Mental Health Act. He no longer has any restrictions. He is entitled to Section 117 aftercare arrangements from the Local Authority.
Mental capacity assessment	Please see capacity assessments relating to: - Finances - Health - Support

Care and support plan

Needs, concerns or health problems	Goals	Actions		Outcomes	Person completing record
Managing anxiety	To provide Andy with strategies for expressing and coping with anxiety. To reduce things that make him anxious.	- Regularly rehearse breathing exercises - Promote communication of "I am anxious" - Ensure consistent response from support to anxiety - Clear structured weekly timetable	**Who:** Community Learning Disability Team **Status:** Started **Date:** 02/09/2017	On-going	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust

Communication	To increase Andy's communication skills.	- Ensure Picture Exchange Communication System is in place and used consistently. - Clear communication guidelines to be followed by all. - Develop communication passport to share communication needs with others.	**Who:** Community Learning Disability Team **Status:** Not started **Date:** 02/09/2017	On-going	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust
Keeping safe	To manage the risk of Andy running into the road when anxious or excited.	- Develop a strategy to be used consistently by the team, e.g. encouraging "walk with me". - Using energy proactively with running activities. - Social story about road safety to be read before each outing. - Clear crisis plan for managing behaviour when running occurs.	**Who:** Community Learning Disability Team **Status:** Started **Date:** 02/09/2017	Partially achieved	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust
Epilepsy management	To ensure support is able to provide safe and effective support during seizures.	- Liaise with epilepsy nurse	**Who:** Care-coordinator **Status:** Completed **Date:** 02/09/2017	Partially achieved	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust
		- Share Epilepsy care plan with Community Learning Disability Team	**Who:** Epilepsy Nurse **Status:** Completed **Date:** 23/09/2017		**Name:** John Adams **Role:** Epilepsy Nurse **Contact:** 020 345 6789, john.adams1@nhs.net **Organisation:** NHS

		- All team members to be familiar with epilepsy support plan. - Rescue medication to be available at all times. - Consistent recording of seizures to be followed to support Neurology reviews.	**Who:** Community Learning Disability Team **Status:** Started **Date:** 03/10/2017		**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust

Planned review date/interval	Responsibility for review	Date this plan was last updated	Updated by
Monthly	Community Learning Disability Team, **Contact:** 020 345 6788, CLDT@nhs.net **Organisation:** NHS Trust	03/10/2017	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust

Additional supporting plans

Plan name	Planned review date/interval	Responsibility for review
Epilepsy	Monthly	Epilepsy Nurse
Communication	Monthly	Speech & Language Therapist
Anxiety	Monthly	Learning Disability Nurse
Keeping safe	Monthly	Team manager

Contingency plans

Plan name	Trigger factors	What should happen	Who should be contacted	Anticipatory medicines/ equipment	Person completing record	Date this plan was last updated	Planned review date	Responsibility for review
Mental health	Andy is running away from support on more than one occasion per week	- Review physical health needs - Review anxiety - Review incidents and look for patterns - Increase supervision and support	- Parents - Community Learning Disability Team	Proactive use of PRN Lorazepam may be considered to reduce anxiety,	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust	02/09/2017	Monthly	**Name:** Tom Smith **Role:** Care-coordinator **Contact:** 020 345 6789, tom.smith5@nhs.net **Organisation:** NHS Trust
Epilepsy plan	Increase in seizure activity	- Review physical health - Increase monitoring	- Parents - Community Learning Disability Team - Neurology - Possibly GP	Ensure Buccal Midazolam is carried at all times	**Name:** John Adams **Role:** Epilepsy Nurse **Contact:** 020 345 6789, john.adams1@nhs.net **Organisation:** NHS Trust	23/09/2017	Monthly	**Name:** John Adams **Role:** Epilepsy Nurse **Contact:** 020 345 6789, john.adams1@nhs.net **Organisation:** NHS Trust

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