

Care Planning Resources

- QOF annual review templates available for EMIS Web and SystemOne practices
- Two versions:
 - highly coded to support audit/helps those with less care planning experience to ask the right questions
 - the other 'Light' version includes more free text

Dementia Annual Review

DEMENTIA QOF 15/16 REQUIRES FACE TO FACE CARE PLANNING WITH THE PATIENT. It would be good practice (with the patient's consent) to invite the carer to the review.

The appointment should be with a suitably qualified clinician, not necessarily a GP. The care plan is not required to be carried out all at once and it is at the clinicians discretion which sections are completed. This template is intended to aid the consultation, not provide a rigid structure.

It is good practice to allow patients to think about what they wish to discuss during review. Please give the patient the 'What makes a difference' information sheet. Where possible this should be given before and discussed during the review.

[What makes a difference](#)

"What good looks like" ----->

YHCS Integrated Care Dementia Pathway

1) All newly diagnosed patients should be considered for ACP to help plan for future decision making. ACPs should be reviewed annually to ensure the patient's wishes have not changed.

YHCS Advance Care Planning

Review of dementia advance care plan



2) Review both the patient's and their carer's support needs and offer a carer's health check

[Jump to Living with Dementia page](#)

3) Review the patient's physical, emotional and medication needs (falls, continence, skin, nutrition)

[Jump to physical health check page](#)

4) Assess the patient's behaviour, risks/safeguarding and driving needs

[Jump to Risks & behaviours page](#)

5) Initially consider at what stage of Dementia the patient is at to ensure appropriate care planning

YHCS Dementia Global Deterioration Scale

YHCS Dementia Staging Tool

6) Consider if the patient is suitable for inclusion on to the Avoiding Unplanned Admissions register? this will allow an MDT approach and 3 monthly follow up of those at risk.

[Jump to AUA ES page](#)

7) Finally, consider if the patient is approaching end of life and whether they may benefit from inclusion in the gold standards framework & Palliative Care register.

[Jump to End of Life page](#)

Dementia care plan codes

Dementia care plan review code

Dementia care plan exception c...

New Recall

Review of dementia advance care plan

Date ▾ | Checked | ...

No previous values

Show recordings from other templates

Show empty recordings

Information

Print

Suspend

Ok

Cancel

Residence, Care & Support

Residence

Place of Residence

Patient Personal Concerns and Goals - include details of the main issues and goals of the patient and carer

Identifying personal goals

Social Circumstances: includes details of patient's social circumstances this could include details about their residential and accomodation circumstances eg; house/flat/stairs/aid adaptions eg: stair lifts etc

Social circumstances

Activities - include details of how the patient is engaging with family/friends/community

Activities of everyday life

Support

Support record who is caring for the patient and which services they are accessing. You can click on the preset button under the pencil button to add pre-configured options.

Support services in place

- Under care of social services (XaLKF)
- Receives help from voluntary agency (U...
- Meals on wheels (13G7.)
- Attending day centre (XaLLI)
- Mental health carers' respite (XaIOW)

Mental health key worke...

Support services required

- Home help needed (13G64)
- Needs an advocate (Ua2AK)
- Referral to Social Services (XaAey)
- Referred for telecare (XaMic)
- Arrange meals on wheels (13U12)

Community Nursing

Under care of team

- Under care of psychiatrist (XaA...
- Under care of mental health tea...
- Seen in memory clinic (XaNbm)

- Under care of continence nurse...
- Under care of community-base...
- Under care of dietitian (XaARG)

Carers

Has a carer (who is)



Record Carer

Patient's next of kin



Record Relationship

If the patient has a carer who is registered within the practice, they should be offered a Carers Annual Health Check. If the patient is registered elsewhere, please advise them to contact their usual GP to discuss.

The Carers health check should be completed within the carer's record.

You must record **Carer of a person with Dementia - XaZ4h** to satisfy the Dementia DES.

Patient is a carer



YHCS Carers Health Check



NICE



Alzheimers Society - Caring

TESTING Dementia Annual Review Care Planning Light

Contents | Residence, care & support | Medication | Physical health check | Risks and behaviours | AUA ES | End of Life

Residence, Care & Support

Residence

Place of Residence

Record patient's preferences about where they would prefer to be looked after if they became suddenly or seriously unwell:

Preferred place of care

Social Circumstances: includes details of patient's social circumstances this could include details about their residential and accomodation circumstances eg; house/flat/stairs/aid adaption eg: stair lifts, lives alone, housebound etc

Social circumstances

Support

Support: record who is caring for the patient and which services they are accessing.
eg: Mental Health, Domicillary Care, Meals on Wheels, Social Services, Other Healthcare Professionals

Under care of team

Carers

Has a carer (who is) Patient's next of kin

If the patient has a carer who is registered within the practice, they should be offered a Carers Annual Health Check. If the patient is registered elsewhere, please advise them to contact their usual GP to discuss.

The Carers health check should be completed within the carer's record.

You must record 'Carer of a person with Dementia - XaZ4h' to satisfy the Dementia DES.

Patient is a carer [NICE](#) [Alzheimers Society - Caring](#)

Place of Residence

Date ▼	Selection	...
No previous values		

Show recordings from other templates

Show empty recordings

Template Runner

Pages <<

Annual Review

Cognition and Medication

Risks and Behaviours

Avoiding Unplanned Admissions

End of Life

Dementia Annual Review

DEMENTIA ANNUAL REVIEW

Dementia QOF 15/16 requires face to face care planning with the patient.

1. All newly diagnosed patients should be considered for Advance Care Planning. ACPs should be reviewed annually to ensure the patient's wishes have not changed.
2. Review both the patient's and their carer's support needs and offer a carer health check.
3. Review the patient's physical, emotional and medication needs (falls, continence, skin, nutrition)
4. Assess the patient's behaviour, risks/safeguarding and driving needs.
5. Initially consider at what stage of Dementia the patient is at to ensure appropriate care planning.
6. Consider if the patient is suitable for inclusion on the Avoiding Unplanned Admissions register? This will allow an MDT approach and 3 monthly follow up of those at risk.
7. Finally, consider if the patient is approaching end of life and whether they may benefit from inclusion in the gold standards framework and Palliative Care register.

Dementia annual review

No previous entry

Living With Dementia

Place of Residence

No previous entry

Text

Preferred Place of Care

03-Jul-2014 Preferred pla... >

Text

Patient Personal Concerns and Goals

Please record any details of patient's social circumstances. This could include details about their residential and accomodation circumstances e.g. house/flat/stairs/aid adaptions etc

Social Circumstances

Activities (how patient is engaging with family, friends, community etc

Support - record who is caring for the patient and which services they are accessing.

Support services required or in place

No previous entry

Community Nursing

No previous entry

Mental Health Key Workers

No previous entry

Under Care Of Team:

Under Care Of Team:

Has a carer

No previous entry

Patient's next of kin

No previous entry

If a patient has a carer who is registered within the practice they should be offered a Carers' Annual Health Check. If the patient is registered elsewhere please advise them to contact their own GP to discuss.


The Carer Health Check should be completed within the carer's record and you must record **'Carer of a person with dementia (918y.)'** to satisfy the Dementia DES.

Cancel

Cognition & Medication

Please consider any medication issues that may adversely effect cognitive functioning e.g. >4 medications, anti-cholinergics, antipsychotics, psychotropic, sleeping tablets.

Medication review done




Any observed changes in memory/orientation (eg getting lost)/recognising familiar people

Cognitive function observations



Compliance

Drug compliance checked



Compliance issues discussed with patient




Drug compliance

- Drug compliance good (8B3E.)
- Drug compliance poor (Xalwn)



Drug compliance aid requested



Understanding

- Patient understands why taking all medication (XaJKW)
- Patient does not understand why taking all medication...



Uses dispensed monitored dosage system



Antipsychotics

Antipsychotics should be used with extreme caution and consider referral to OP CMHT prior to use.

When used antipsychotics should be time limited and regularly reviewed (at least every three months)

 YHCS Antipsychotics in Older People

Antipsychotic medication review



Acetylcholinesterase inhibitor (AChEI)

Review patient for side effects of diarrhoea, headaches, fatigue.

Check pulse and BP, consider stopping if low.



[Jump to record pulse and BP](#)




Memantine




Review patient for side effects of headache, dizziness, drowsiness, constipation and depression.


No need to monitor pulse rate or BP but may need to decrease the dose in renal impairment


Physical Check


BP mmHg  Pulse b... 


Smoking Status  Advice on smoking  Alcohol int... ... 

Height m  Weight Kg  BMI ... 


General wellbeing 

Mobility Fully mobile (13C1.)  Mobile outside with aid (13C2.) Mobile in home (13C3.) Needs walking aid in home (13C4.) Confined to chair (13C5.) Bed-ridden (13C6.)

Continence Continent (X907J)  Incontinence of faeces (XE0rG) Urinary incontinence (1A23.) Double incontinence (X30C5)


Falls At risk of falls (XaISz)  Recurrent falls (Xa1GP) Multidisciplinary team falls assessment d... At risk of osteoporotic fracture (XaIT0)

Influenza, Tetanus and Pneumococcus Status

 Record Vaccination

YHCS Immunisation History view cannot be shown without a patient

For any identified needs consider referrals to:

Referral made to: Referral to community-based nurse (XaAh8)  Referral to dietitian (XaBSz) Referral by continence nurse (XaAb2) Referral to occupational therapy service (XaAda) Referral to physiotherapist (XaBT0) Refer for falls assessment (XaISu)

TESTING Dementia Annual Review Care Planning Light

Contents | Residence, care & support | Medication | Physical health check | Risks and behaviours | AUA ES | End of Life

Physical & Mental Health Check

BP mmHg Pulse b...
 Smoking Status Advice on smoking Alcohol int... ...
 Height m Weight Kg BMI ...

General wellbeing

Mood/anxiety/depression

Cognitive function observations

Mobility/Falls

Consider activity levels & falls risk

Observation of mobility

Continence Continent (X907J)

- Incontinence of faeces (XE0rG)
- Urinary incontinence (1A23.)
- Double incontinence (X30C5)

Influenza, Tetanus and Pneumococcus Status

Record Vaccination

For any identified needs consider appropriate referrals & give information on local services. Please record below.
 eg: continence nurse, befriending service, dementia advisor, social services, benefits advice, mental health services

Referral to service

Advice regarding provision of local health services

Risks, Behavioural & Psychological needs

eg: bored, frustrated, withdrawn

Mood/anxiety/depression



Adult protection issues

Vulnerable adult



Bradford Guidelines:



[Bradford Safeguarding Adults](#)



[NICE](#)

Behaviours

Behaviours that challenge

- Feeling agitated (Ua15v)
- Verbal aggression (X7658)
- Physical aggression (X7659)
- Self-neglect (X766C)
- Wandering (X75ym)
- Inappropriate sexual behaviour (X7673)



Consider early referral to OP CMHT & Care Home Liaison teams



Referral to:



Driving

Dementia is a condition that you need to tell the Driver & the DVLA about

Driving status



Patient advised about driving



Patient advised to inform DVLA



Education : Implications to license



Patient advised to inform insurance company



[DVLA Form](#)

[Alzheimers Org - Driving & Dementia](#)

Risks

Risks - please select all that apply

- Risk of self neglect (Xalv1)
- At risk of falls (XalSz)
- Drug compliance poor (Xalwn)



Click here to print information for the patient to take



High risk patients may benefit from inclusion onto the Avoiding Unplanned Admissions ES register

[Jump to AUA ES page](#)

Is your patient suitable for the Avoiding Unplanned Admission ES?

The Avoiding Unplanned Admission ES allows a more proactive MDT approach to care, with regular care planning reviews every 3 months. Patients diagnosed with more moderate and severe dementia often benefit.


Patient identified as At Risk of Unplanned Admission. Tick the box below to add the patient to the Case Management register.

Admission avoidance care started   YHCS Avoiding Unplanned Admissions ES


Named accountable GP & Clinical Co-ordinator


Please assign any patients onto the Case Management Register with a GP using Relationships.

NB: All patients over the age of 75 should already have a named GP assigned.

 Record GP

Where appropriate you may wish to assign the patient with a Clinical Co-ordinator

 Record Clinical Coordinator


Informing patient of named accountable general practitioner 


Avoiding Unplanned Admissions Care Plan 

 Record Sharing

[Is the patient reaching the last years of life?](#)

Please use the two enclosed rating scales to identify people with severe dementia who may be suitable for the Gold Standards Framework and palliative care planning

 [YHCS Dementia Staging Tool](#)

 [YHCS Dementia Global Deterioration Scale](#)

GSF Prognostic Indicators for the Dementia

Triggers to consider that indicate that someone is entering a later stage are:


- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- No consistently meaningful conversation
- Unable to do Activities of Daily Living (ADL)
- Barthel score <3

Plus any of the following:

- Weight loss
- Urinary tract Infection
- Severe pressures sores - stage three or four
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia

GSF Planning


This template covers end of life decisions and anticipatory care but it is not only for patients in the last days of life. Please consider filling it in and discussing the issues embedded within where capacity may be impaired (or is likely to become impaired) or where health is anticipated to deteriorate rapidly in the next few years. Areas covered are resuscitation status, preferred place of care, lasting power of attorney and advance statements and decisions to refuse treatment

 [YHCS Advance Care Planning](#)

Click here to quickly record the GSF status of this patient:

 [YHCS Palliative Care Coordination System EPaCCS \(page 3\)](#)

Consider completing the YHCS End of Life (EPaCCS) template.

 [YHCS Palliative Care Coordination System EPaCCS](#)

Care Planning Resources

- QOF annual review templates available for EMIS Web and SystemOne practices
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 - the other 'Light' version includes more free text
- **Questionnaire for patient and carer**
(source: Year of Care)

What could really make a difference?

Name:

Completed with:

Date:

This leaflet is designed to help you and your family and carers think about how things are working for you at the moment and what ideas you have that could really make a difference for you. Please take your time to think through the questions and write down any thoughts and ideas you have. You can then discuss these ideas with your key worker when you review your care and support package.

How are you doing?



I am
coping fine



I am
doing OK



I am not
coping so well



These are some things that people sometimes want to talk about.
Circle any that are important to you.

Bathing and Hygiene	My current care	Supporting my family/carers	Feeling lonely
Finances	Lack of control	Feeling hopeless	Pain
Feeling low or stressed	Feeling scared	Eating and drinking	Mobility
Taking medication	My future health	Alcohol	Physical activity
Keeping warm	My memory	Hearing	Smoking
Staying steady	My weight	Slowing down	My sight



©Year of Care|

What is important to you?

What is working well?

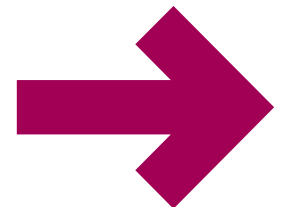
What isn't working so well?

What needs to change?

What ideas do you have?

Care Planning Resources

- QOF annual review templates available for EMIS Web and SystemOne practices
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 - the other 'Light' version includes more free text
- Year of Care Questionnaire for patient and carer
- **Printable patient-held care plan**
 - **Still in development**
 - **Going to Service User Reference Group next week**



Patient Name: Mouse Micky Mr
 Today's Date: 10 Jul 2015
 Dementia Care Plan


Mouse Micky Mr
NHS Number:

Date of Birth: 25 Apr 1965

Gender: Male

Language: language not specified

CONTACT DETAILS

 Current Home Address: 7 Park Top Cottages
 Bingley
 West Yorkshire
 BD16 3DB

Mobile Tel. (preferred):

Home Tel: 01274 555 5555

REGISTRATION DETAILS

Practice:

Review Date:

THIS IS WHAT WE KNOW ABOUT YOU
Your concerns and goals

10 Jul 2015, Identifying personal goals, personal goals text

Your social circumstance and activities

 10 Jul 2015, Social circumstances, social circs text
 10 Jul 2015, Activities of everyday life, activities text
 10 Jul 2015, Lives in own home
 10 Jul 2015, Has a carer, carer name

 10 Jul 2015, Patient's next of kin, NOK freetext
 SURNAME, Nok

This is support you receive

 10 Jul 2015, Attending day centre
 10 Jul 2015, Under care of continence nurse
 10 Jul 2015, Under care of psychiatrist
 10 Jul 2015, Patient themselves providing care
 10 Jul 2015, Under care of team, Virtual ward

THIS IS WHAT WE FOUND OUT TOGETHER

These are the findings of our physical health check

10 Jul 2015, Never smoked tobacco
10 Jul 2015, Alcohol intake 0
10 Jul 2015, Vulnerable adult
150 / 90 mmHg
10 Jul 2015, Pulse, 80 bpm
10 Jul 2015, O/E - weight, 52 Kg
10 Jul 2015, O/E - height, 1.54 m
10 Jul 2015, Body mass index - observation, 21.93 Kg/m²
10 Jul 2015, General wellbeing, general wellbeing text
10 Jul 2015, Mobile in home
10 Jul 2015, Recurrent falls
10 Jul 2015, Incontinence of faeces

These are the medication you are on

Current Acute Issues:

Current Repeat:

These are the results of your medication review

10 Jul 2015, Drug compliance good
10 Jul 2015, Patient understands why taking all medication
10 Jul 2015, Compliance issues discussed with patient
10 Jul 2015, Drug compliance checked

This is what you told us about how your memory is working

10 Jul 2015, Cognitive function observations, cog obs text

This is what you told us about your mood

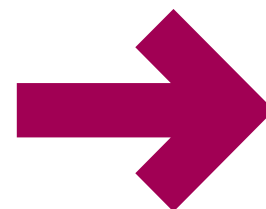
10 Jul 2015, Level of mood, mood text

These are the risks that you and your carer are concerned about

10 Jul 2015, Drug compliance poor
10 Jul 2015, Risk of [self neglect](#)
10 Jul 2015, Self-neglect
10 Jul 2015, Wandering
10 Jul 2015, Inappropriate sexual behaviour
10 Jul 2015, Feeling agitated
10 Jul 2015, Verbal aggression
10 Jul 2015, Physical aggression

This is what you have told us about your driving

10 Jul 2015, Does drive a car



ADVANCE CARE PLANNING DATA

These are the future decisions in your Advance Care Plan

Resuscitation discussed with carer, 10 Jul 2015

Resuscitation discussed with patient, 10 Jul 2015

WHAT WE HAVE DECIDED AND DONE TOGETHER

Your referrals and next step for your practice/GP

10 Jul 2015, Referral by continence nurse

10 Jul 2015, Referral to occupational therapy service

10 Jul 2015, Referral to physiotherapist

10 Jul 2015, Referral to Social Services

10 Jul 2015, Drug compliance aid requested

10 Jul 2015, Referral to dietitian

10 Jul 2015, Referral to psychiatrist for the elderly mentally ill

What advice we have given you

10 Jul 2015, Advice on smoking

10 Jul 2015, Patient advised to inform insurance company

10 Jul 2015, Patient advised about driving

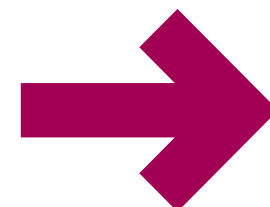
10 Jul 2015, Education : Implications to license

What reviews we have done together

10 Jul 2015, Medication review done

10 Jul 2015, Antipsychotic medication review

10 Jul 2015, Patient advised to inform DVLA



ALL KNOWN RELATIONSHIP

GP: SURNAME, Dr , 5434325420542

Clinical Coordinator: CO-ORDINATOR, Clinical, 213415641254187

Care: SURNAME, Care, 07777777777777

Next of Kin: SURNAME, Nok, 0214564231864

Power of Attorney:

SENSITIVITY & ALLERGY SUMMARY

