

# **Integrated Care Product Description**

## **Staying Well Check Tool**

Product Title	Staying Well Check Tool
Product Owner	Staying Well, Bolton Council
Contributors	Bolton Council Public Health Team
Format	PDF Document
Description	<p><b>Purpose:</b> The Staying Well Check Tool developed by Bolton Council's Public Health Team supports to identify client risk factors for future health and social care need. In addition to age, physical health and mental health, risk factors are likely to be linked to lack of social support, physical living environment and economic difficulties.</p> <p><b>Components:</b> This product includes items from the toolkit:-</p> <ul style="list-style-type: none"> <li>• Project Brief</li> <li>• Consent Form</li> <li>• Quality Of Life Wheel</li> <li>• Staying Well Check Key Principles</li> <li>• Visual Communication Cards</li> <li>• Triggers Questions</li> <li>• Algorithm Example</li> <li>• Visit Summary Information Template</li> <li>• A training package is currently being developed to coincide with this Staying Well Check Tool.</li> </ul>
Review	31 <sup>st</sup> March 2016
Approval	Staying Well - Bolton Council Public Health Team

## **Project Brief**

Bolton Councils Public Health Team working with local partners, including NHS Bolton Clinical Commissioning Group (CCG), implemented a Staying Well feasibility Project to support adults 65 and over to maintain their independence.

Through the Staying Well Project, partners across the health and social care system are working together to systematically identify individuals at high risk of developing future health and social care need and providing advice and support to enable them to remain as healthy and independent as possible for as long as possible.

The project is led by the Bolton Council's Public Health Team, and also includes the Council's Adult Social Services, Strategic Housing, and Customer Services Department, alongside NHS Bolton CCG.

Staying Well works by using GP practice registers to identify people aged 65 or over who are not yet in receipt of social care but are at high risk of requiring future intervention or support. These patients are contacted proactively and invited to take part in a holistic Staying Well Check in their own home.

Through the Staying Well Check, Staying Well Coordinators undertake a person-centred conversation with individuals, discussing issues they are facing and signposting or referring them to appropriate services, information and support. The focus of the check is on helping individuals to remain healthy, happy and independent at home for longer.

The Staying Well Check Tool developed by the project supports Well-being Coordinators, and other health and care professionals, to work with individuals to identify their personal risk factors for future health and social care need. The Tool has been designed to support a two way open conversation between the Coordinator and individual. The quality of life wheel and visual picture cards developed as part of the tool have proven to be particularly useful with clients who have language and communication difficulties.

The approach is currently being tested in 6 GP practices across Bolton; emerging findings are encouraging both in terms of the feasibility of potential roll out and in achieving positive outcomes. Potential benefits of the project include:

- More people able to maintain health and independence.
- Reduced GP visits.
- Reduced or delay in need for intensive health and social services, including crisis
- Intervention costs
- More efficient targeting and use of resources.

The data analysis enabled by this project will inform future commissioning of preventative health and social care services.

For more information about the Staying Well Project contact Munisha Savania on 01204 337321 or email [Munisha.savania@bolton.gov.uk](mailto:Munisha.savania@bolton.gov.uk)

## **Consent Form**

To be able to support clients with the appropriate timely support, it was vital to gain consent from the clients at the beginning of the process enabling the Staying Well Coordinators to share information with other services. This supported clients not having to re-tell their story every time they come across a new service or not getting the support they need due to different services not being able to talk to each other and share appropriate information.

For the purpose of the service the consent form is adapted to include other parts, where client consent is required.

## Staying Well Consent Form

	YES	NO
1. I agree to take part in the Staying Well Service and agree to personal information being shared with other organisations/services to ensure I receive the advice and support I need. I understand that this will only be done with my consent.	<input type="checkbox"/>	<input type="checkbox"/>
2. I understand that my participation is voluntary and I am free to withdraw consent at any time.	<input type="checkbox"/>	<input type="checkbox"/>
3. I agree to being contacted in the future about further studies relating to Staying Well Feasibility Service.	<input type="checkbox"/>	<input type="checkbox"/>
4. I consent for you to contact my carer e.g. neighbour, relative or friend.	<input type="checkbox"/>	<input type="checkbox"/>
5. I consent to images, videos of me and quotes being used in publication and any other media for the purpose of the Staying Well Service Only. I understand I can change my mind at any time by informing the Service.	<input type="checkbox"/>	<input type="checkbox"/>

Carers Name \_\_\_\_\_

Carers Telephone/Email \_\_\_\_\_

Clients Name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Telephone \_\_\_\_\_

Email Address \_\_\_\_\_

Signature of Participant \_\_\_\_\_

To be completed by the Co-ordinator	
Client ID	
Practice ID	
Co-ordinator name	

Date -----

## Quality of Life Wheel

The Staying Well Quality of Life Wheel forms the first stage of the Staying Well Check. It is designed in a visually appealing way to provide a tool to enable the client & Staying Well Coordinator to engage in a holistic conversation about the client's current quality of life, with the view of preparing the client to think about their potential future needs. The Staying Well Check uses this as a basis to identify what is going well & less well for the client. Clients are asked to score themselves on a scale of 0-5, with 0 being "I am very unhappy this is a big concern to 5 being "I am very happy, no issue at all". The Staying Well Check then continues to probe deeper into the areas identified as going less well, with the aim of identifying actions and goals. The check draws & builds on the individual's assets identified by the check.

The Quality of Life Wheel identifies 12 themes for discussion. A literature review was performed before the service started, which sought to identify modifiable factors that were associated with an increased risk of needing specialist health and social care services. The 12 themes are based on the results of this literature review & a focus group with older people likely to be similar to the future Staying Well clients.

The 12 themes include: -

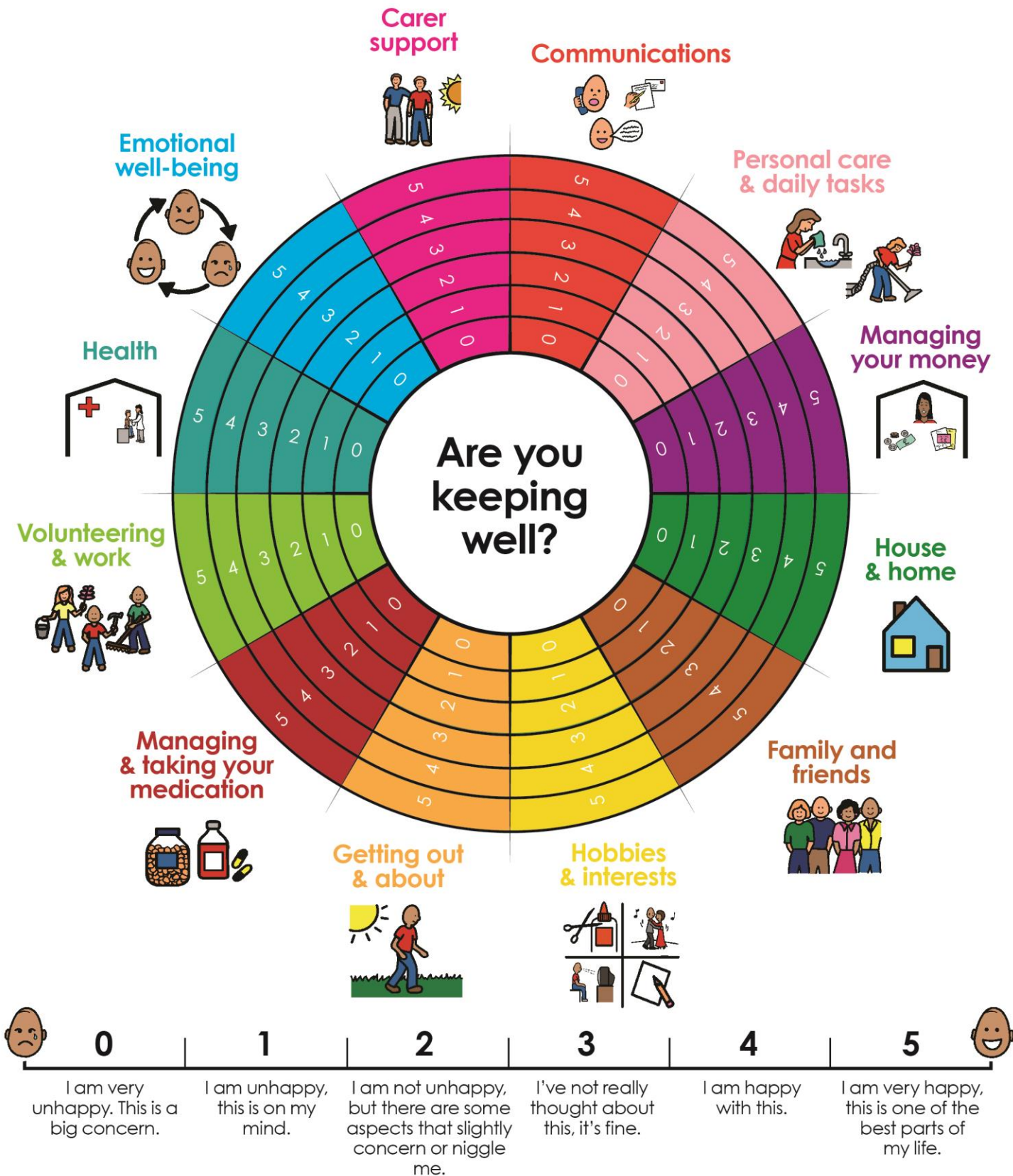
- Health
- Carer Support
- Emotional Well-being
- Getting out and about
- Personal Care and daily tasks
- House and Home
- Managing Medication
- Managing Money
- Friends, Family and People
- Communication
- Volunteering and Work
- Hobbies and Interests

The theory behind this approach is that being 'at risk of future health and social care need' translates into having a deficit on one or more of the 12 themes in the quality of life wheel, and that removing or reducing this deficit, through harnessing of assets, will reduce their risk.

The risk factors that pre-determine the need for intensive health and social care support do not sit in isolation. The interaction between risk factors is very important as certain risks increase the likelihood of other risks and combinations of risks can further increase levels of risk. Some risks can trigger on-going spirals and feedback loops which lead to increasing levels of risk, such as an old person who fears falling may be reluctant to leave their home and so may experience reduced levels of social participation. In turn this may increase the risk of depression which may further decrease the levels of social participation and therefore increase the risk of further depression. Staying Well Co-ordinators identify this deficit & enable person to access services or make changes to reduce this deficit thus reducing their risk.

# Integrating Health & Social Care Quality of life wheel

Using the scale at the bottom of this page, tell us how happy or unhappy you are using the key categories from the quality of life wheel. Please rate these from 0-5.



Scoring of 0-2 will need a further detailed conversation to identify appropriate information, advice and support

**Produced by Bolton Council - Public Health Department®**





# Quality of Life Wheel Score Descriptions



0	1	2	3	4	5
I am very unhappy. This is a big concern.	I am unhappy, this is on my mind.	I am not unhappy, but there are some aspects that slightly concern or niggle me.	I've not really thought about this, it's fine.	I am happy with this.	I am very happy, this is one of the best parts of my life.
This worries me a lot and I wouldn't know where to go and who to ask for help.	I'm struggling and aware of my concerns, and trying my best to resolve but need additional support, I don't seem to be resolving this on my own.	I am aware that this could be a bigger problem, if I don't do anything about this. I would need support to point me in the right direction.	I'm fine for now, but thinking and planning for the future will be beneficial to me.	I am confident and have some skills, experiences in this area. I would know where to go and who to ask to access information, support and advice.	I am very confident; I have good skills, knowledge, contacts, training, and experiences in this area. I am fully aware and able to access information, advice and support myself as well as for others.

**Scoring of 0-2 will need a further detailed conversation to identify appropriate information, advice and support**

**Any other services, organisations or individuals wanting to use the Staying Well Tool must adhere to the following:**

**1.**

Gain Permission from  
Bolton Council - Public  
Health Team

**2.**

Bolton Council - Public  
Health Team must see  
approve the revised  
artwork before it is used

**3.**

Services, organisations, individuals are required to  
add a line on the bottom of any artwork saying  
*'Reproduced with kind permission from Bolton  
Council © Bolton Council'*



## **Staying Well Check Key Principles**

- Client centred intervention
- Conversation, not an assessment
- Assets as well as needs
- Not just signposting
- Empowering self-management
- Involved in decision making
- Open & honest communication presented in a way that is understood
- Getting to know client and building trust

## **Visual Communication Cards**

Visual communication cards were developed to form part of the Staying Well Check and aid conversation around the 12 themes of the quality of life wheel. This allows the client to take a moment and reflect on their current quality of life and future risk factors. The cards very much complement the principles of the Staying Well Check by ensuring a client centred conversation allowing the client to identify their own assets, needs, and solutions. The cards have proven to be useful for those clients with communication and language difficulties.

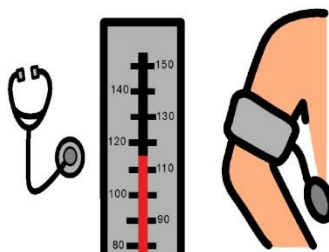
Overall the cards support:-

- Aid a two way conversation
- Gives the service user a moment to reflect
- Allows service user to be in control
- Empowers individual to come up with own their solutions
- Clarifies understanding of each category of the quality of life wheel

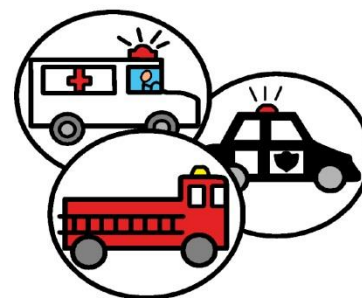
# Carer Support



Caring role



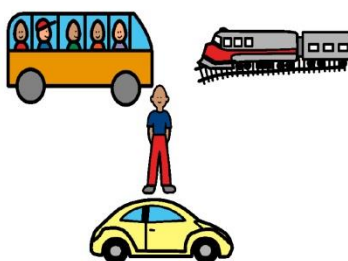
Health



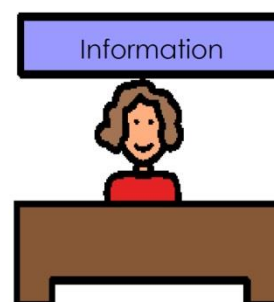
Dealing with emergencies



Family



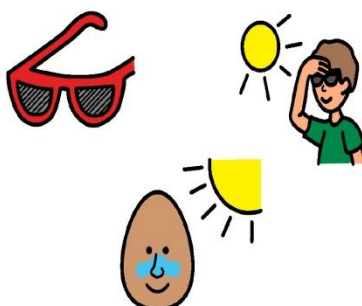
Transport



Information



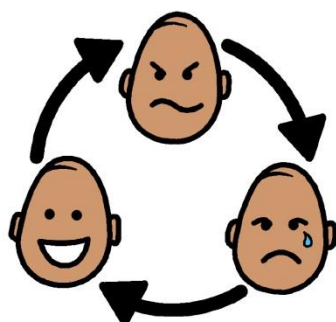
Questions



Break from carer role



Sleep



Emotional wellbeing

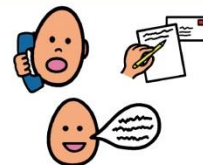


Lifestyle & activities

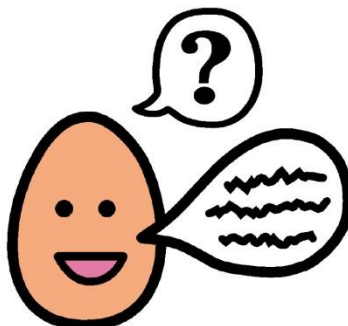


Financial support

# Communication



Writing



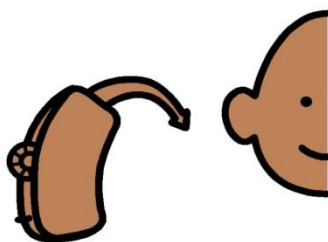
Understanding others



Keeping in touch with people



Hearing



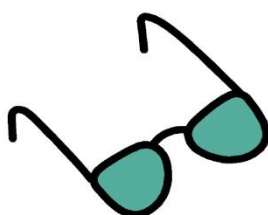
Equipment & aids



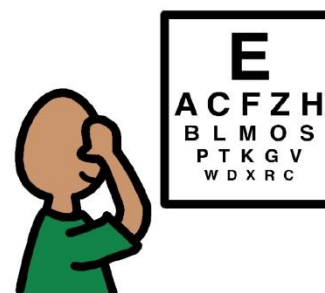
Reading



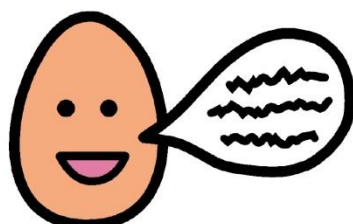
Seeing



Opticians



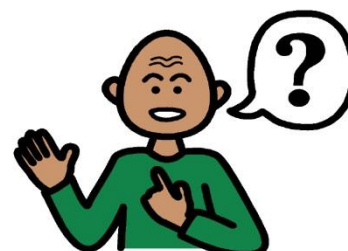
Eye test



Speaking



Swallowing



Questions

# Personal Care & Daily Tasks



Shaving



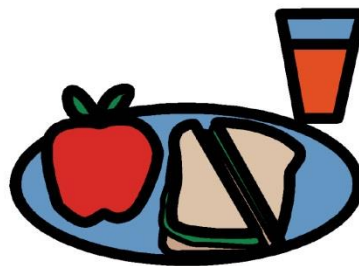
Getting in or out of the Bath / shower



Applying make-up



Managing the toilet



Preparing a snack or meal



Cleaning your home



Feeding yourself



Dressing yourself



Laundry



Combing hair



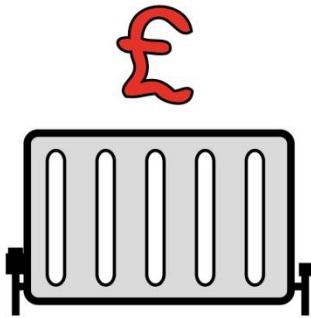
Holding a kettle



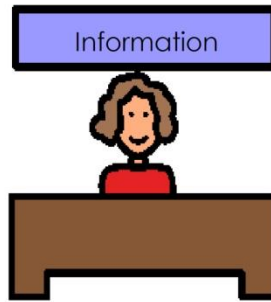
Washing up



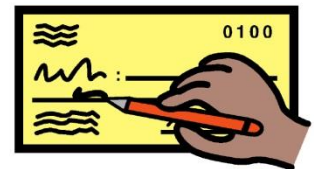
# Managing Your Money



Heating costs



Lack of information



Benefits



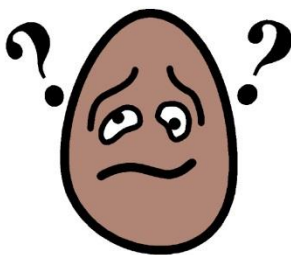
Paying rent



Making payments



Involving others



Confused



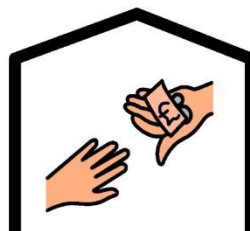
Trusting people & organisations



Bank



Owing money /  
Borrowing money

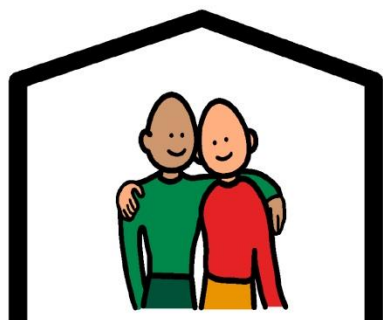


Housing costs

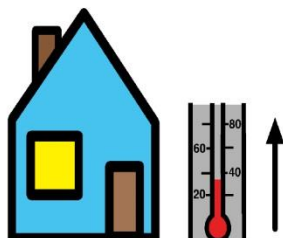


Shopping

# House & Home



Feel safe



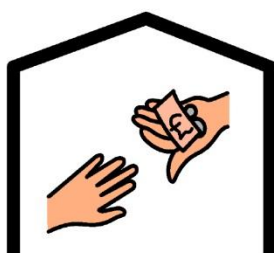
Keep warm



Safe appliances



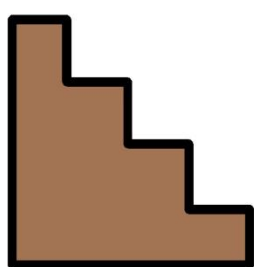
Manage your garden



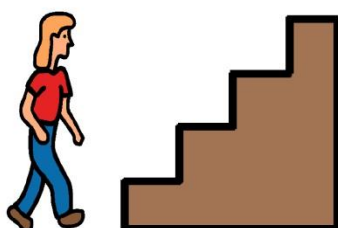
Housing costs



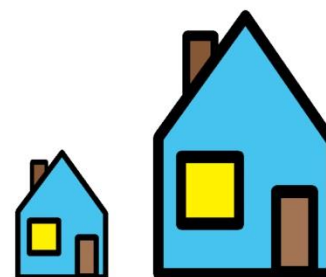
Home repairs



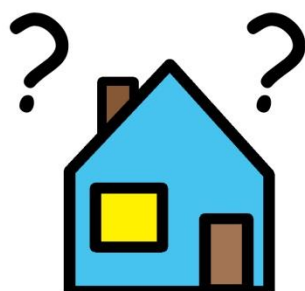
Easy access



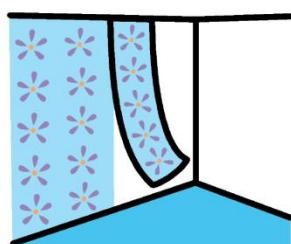
Home adaptations



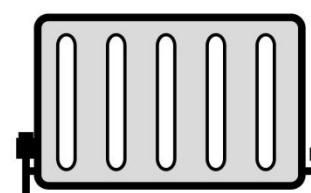
House too big



The future



Damp / mould



Efficient heating



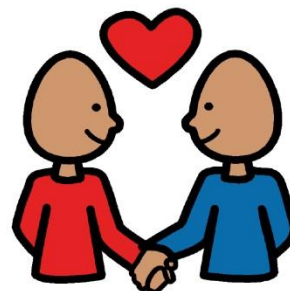
# Family & Friends



Feel supported



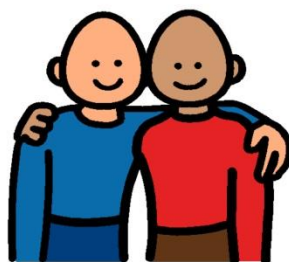
Visit me



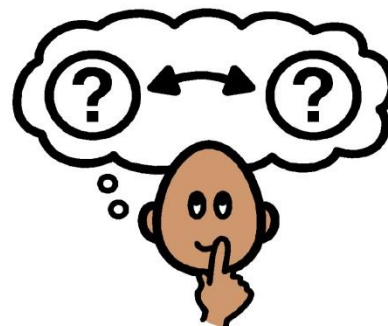
Relationships



Too busy



Support & encourage



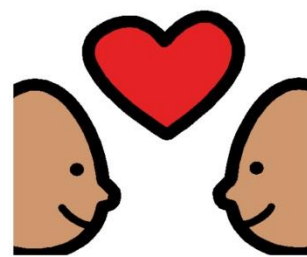
Problem



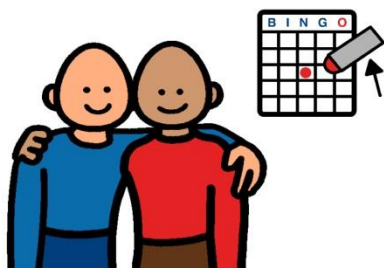
Trust



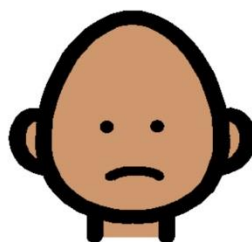
Take care of me



Feel loved



Friends



Loneliness



Speak

# Hobbies & Interests



Arts & crafts



Dancing



Eating out



Reading & writing



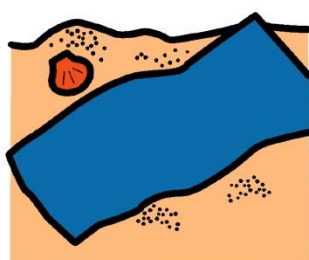
Cooking



Religious faith groups



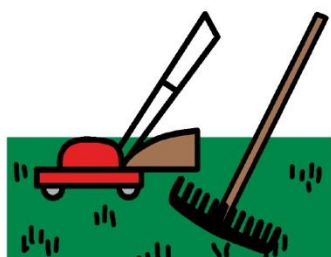
Shopping



Going on holiday



Visiting family & friends



Gardening



Physical activity & exercise



Listening to music

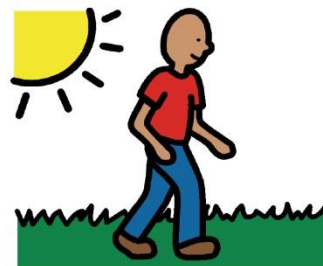
# Getting Out & About



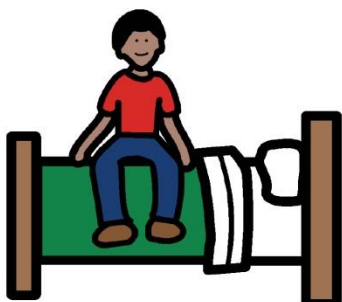
Bank



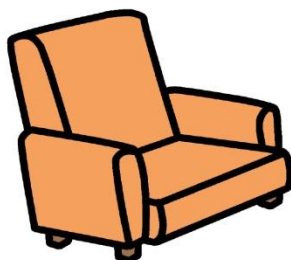
Driving



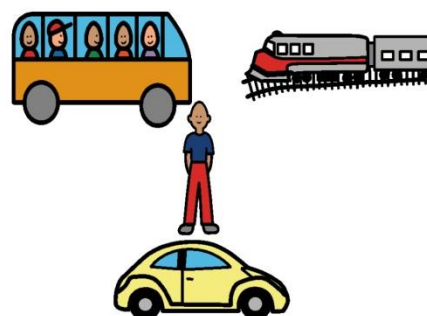
Walking



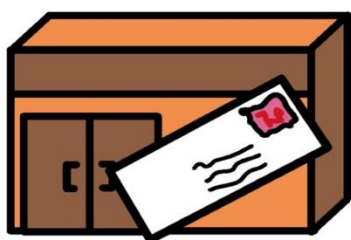
Getting in / out of bed



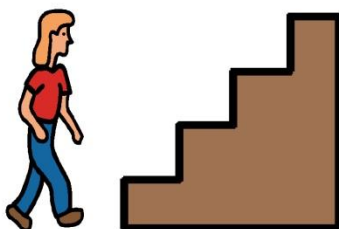
Sitting & standing from a chair



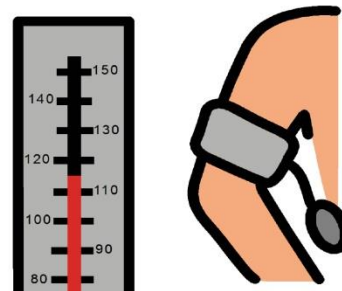
Public transport



Post office



Getting up / down stairs



Health



Shopping



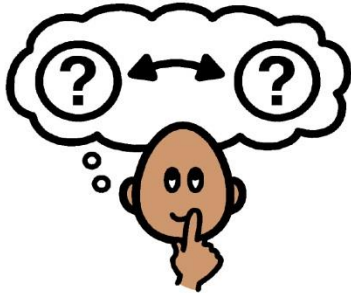
Park



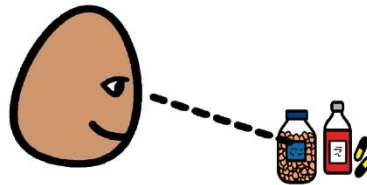
Supermarket



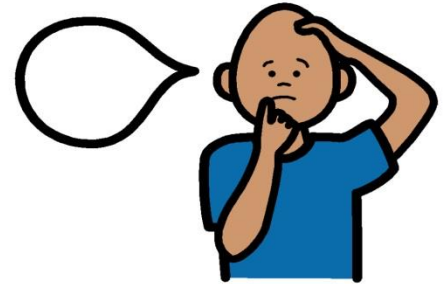
# Managing & Taking Medication



Questions



Reading labels



Forgetting to take medication



Su M T W  
Th F S      Su M T W  
(Th) F S      Su M T W  
Th F (S)

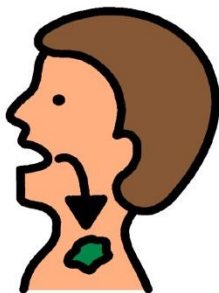
Taking the right dose  
At the right time



Equipment & aids



Ordering & collecting



Swallowing

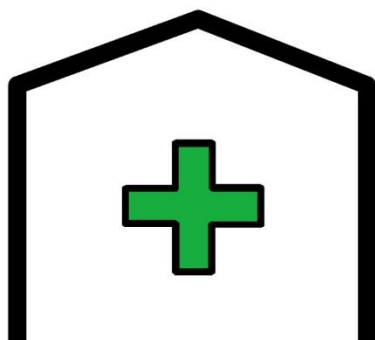


Storing

Su M T W

(Th) F S

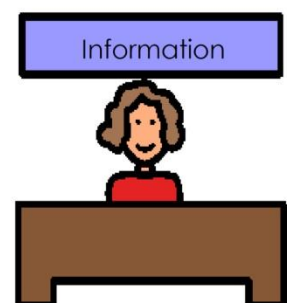
Taking the right medication  
On the right day



Pharmacy



Side effects

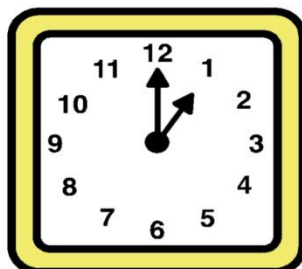


Information

# Volunteering & Work



IT skills



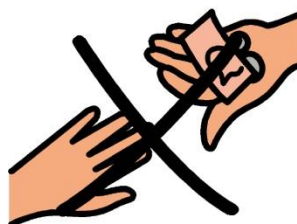
Long hours



I'm too old



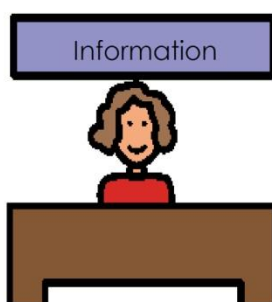
Paid work



Unpaid



Volunteers



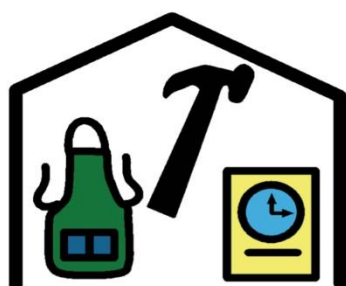
Information



Group work



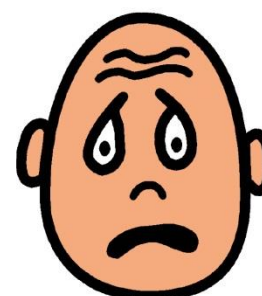
New skills



Manual work

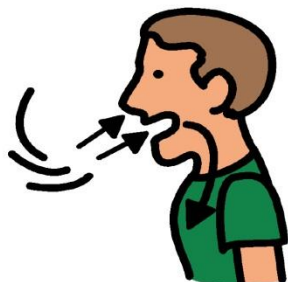


Training courses



Stress

# Health



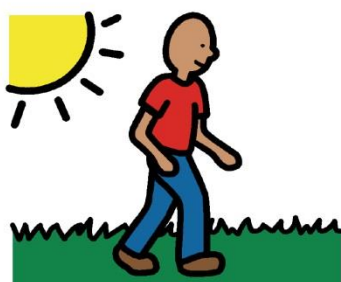
Breathing



Bowel & bladder control



Sleeping well



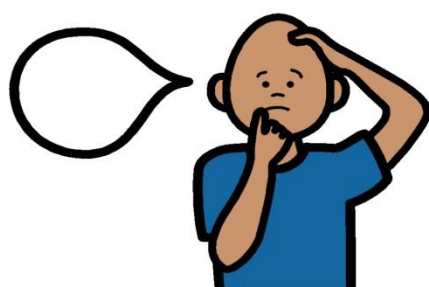
Physical activity



Smoking



Ill



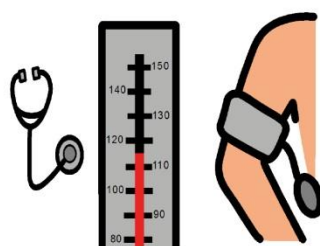
Forgetting things



Pain



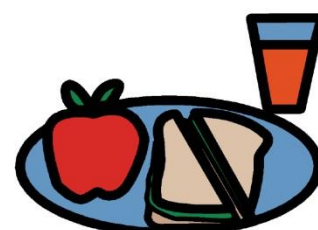
Alcohol



Health check



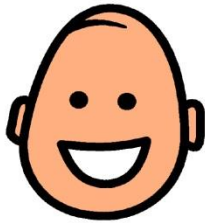
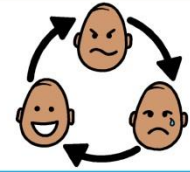
Under or over-weight



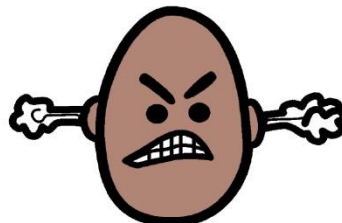
Healthy eating



# Emotional Well-being



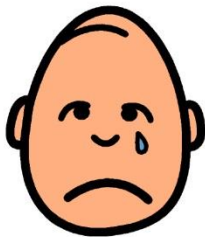
Happy



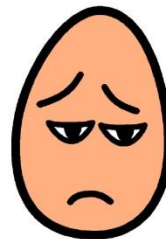
Angry



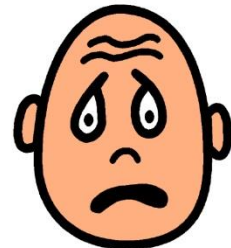
Frustrated



Sad



Unhappy



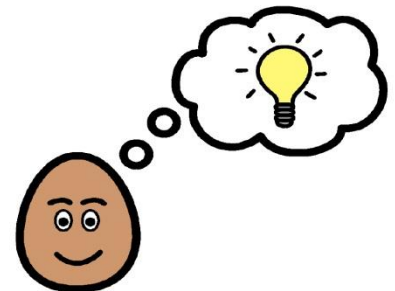
Anxious



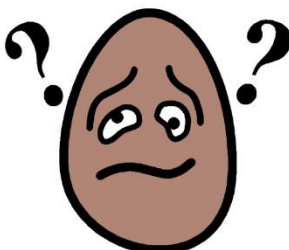
Relaxed



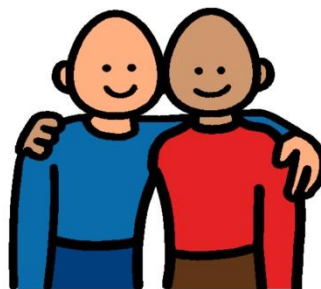
Feel close to people



Thinking clearly



Making decisions



Feeling useful



Tearful



## **Staying Well Client Demographic**

### **( To complete for all clients)**

White ☐

White English/Welsh/Scottish/Northern Irish/British ☐

White Irish ☐

White Gypsy or Irish Traveller ☐

Any other White background ☐

### **Mixed/ Multiple ethnic groups**

Mixed White and Black Caribbean ☐

Mixed White and Black African ☐

Mixed White and Asian ☐

Other Mixed/Multiple ethnic background, please describe ☐

### **Asian/Asian British**

Asian Indian ☐

Asian Pakistani ☐

Asian Bangladeshi ☐

Chinese ☐

Any other Asian background (Please describe) ☐

### **Black/ African/Caribbean/Black British**

Black African ☐

Black Caribbean ☐

Any other Black/African/Caribbean background ☐

### **Other ethnic group**

Arab ☐

Any other ethnic group ☐

**Gender**                      Male ☐                      Female ☐

Date of Birth:

Age:

**Has access to email** Yes ☐ No ☐

Carer Yes ☐ No ☐

Cared For Yes ☐ No ☐

**Who do you live with?**

Live alone ☐  
With Partner Only ☐  
With family ☐  
Other ☐

**Housing Tenure:**

Owner Occupied ☐  
Living rent free ☐  
Private rented ☐  
Social Housing ☐  
Other ☐

**Occupation:**

Employed ☐  
Self Employed ☐  
Retired ☐  
Volunteering ☐

**Consented to share information** Yes ☐ No ☐

**I currently receive help with the following by:- (Please tick)**

	Friends & Family		Provided by Council		Paid for privately		Other	
	Yes	No	Yes	No	Yes	No	Yes	No
Personal Care								
Eating or drinking								
Being part of a community								
Running your home								
Attending day activities								

## Trigger Questions

Behind each of the themes of the quality of life wheel, a set of trigger questions have developed to breakdown identified need. A one to one meeting is undertaken with a range of preventative key services who offer support and services around the 12 key themes of the quality of life wheel. Meeting and working with the key services is very valuable and supported the following points:-

- Avoid duplication-, the trigger questions designed were very much about spotting early warning signs and being able to provide and target appropriate and timely access to information, services and support.
- Ensure consistency in referral/access pathways to support clients effectively.
- The need and asset data has particular been very useful to commissioner's regards future commissioning of services and supporting delivery of key national priorities. This data also supports the development of tailored service provision in response to client's needs, assets and gaps.

Overall the triggers questions support

- To identify actual need/concern/worry
- To effectively target appropriate support
- Spotting/picking up on early warning signs
- Identify current gaps in service provision

## Standard Set Questions to be answered by all clients

### Lifestyle

#### Smoking

Do you smoke? Yes ☐ No ☐

Or use any form of tobacco? Yes ☐ No ☐

- Cigarettes
- Chewing tobacco
- Cigar
- Shisha Pipe

How many do you smoke on average daily? 1-5 ☐ 6-10 ☐

10-20 ☐ 20-30 ☐ 30-40 ☐

Would you like support to stop smoking? Yes ☐ No ☐ (reason)

Do you live with someone who smokes? Yes ☐ No ☐

Any other comments

#### Alcohol

Do you drink alcohol? Yes ☐ No ☐

Question	Scoring System					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	monthly	weekly	Daily or almost daily	

A total of 5+ indicates increasing or higher risk drinking.

Any other comments

### Physical Activity

Do you exercise or undertake activities for at least 150 minutes per week? (Please note this can be in bouts of 10 minutes or more).

Yes ☐ No ☐

Time per activity \_\_\_\_\_  
How many times per week? \_\_\_\_\_

Any other comments

Do you take Vitamin D Supplements? Yes ☐ No ☐ (Give out vitamin D leaflet)

### Food and Health

- |    |  |   |   |
|----|--|---|---|
| 1. | Do you eat 3 meals a day, including a drink?                                 | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/>  |
| 2. | Do you think you eat a balanced diet?  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/>  |
| 3. | Do you enjoy your food/have a good appetite?                                 | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/>  |
| 4. | Has your appetite changed recently?  | Yes <input type="checkbox"/>            | No <input type="checkbox"/>             |
| 5. | How many cups of fluid do you have each day? E.g. water, tea, coffee, squash |   |   |
|    | 0-1 <input checked="" type="checkbox"/>                                      | 2-3 <input checked="" type="checkbox"/> | 4-5 <input checked="" type="checkbox"/> |
|    | 6-7 <input type="checkbox"/>   | <input type="checkbox"/>                | 8+ <input type="checkbox"/>             |

Please use the below 'Food and Health follow on questions' if:

Any of the grey boxes for the above questions are marked

## Routine screening

Have you completed/had any of the following?

Bowel Screening Kit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Breast Screening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Flu Jab	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Abdominal Aortic Aneurysm (Men only 65+)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>

If not, why not (Please state)

	BSK	BS	FJ	AAA
Never received one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I didn't want to take part	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I misplaced the screening kit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I didn't understand how to use it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was too scared to complete/attend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to complete due to mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to read and understand leaflet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to complete due to eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Couldn't make appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I forgot all about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting there was a problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please state)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments

## Emotional well-being

### Standard Question

Tell me about your emotional well-being? (Ask questions below, using the eleven point scale from 0-10 where 0 is 'not at all' and 10 'completely')

Q1- Overall, how satisfied are you with your life nowadays?

Q2- Overall, to what extent do you feel the things you do in your life are worthwhile?

Q3- Overall, how happy did you feel yesterday?

For the above three questions e.g. life satisfaction, worthwhile and happiness questions, ratings are grouped in the following way:

		Q1 SCORE	Q2 SCORE	Q3 SCORE
0 to 4	Low			
5 to 6	Medium			
7 to 8	High			
9 to 10	Very high			



Q4- Overall, how anxious did you feel yesterday?

For the anxiety question, ratings are grouped differently to reflect the fact that higher anxiety is associated with lower well-being. The ratings for anxiety are grouped as follows:

0 to 1	very low	Q4 SCORE
2 to 3	Low	
4 to 5	Medium	
6 to 10	high	

If the client scores low to medium for questions 1, 2 and 3, please complete further questions below using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

If the client scores medium to high for question 4, please complete further questions below using the Warwick- Edinburgh Mental Well-being Scale (WEMWBS)

## Falls

Have you fallen in the last year? Yes ☐ No ☐

What were the potential causes of your fall?

- Time of day ☐
- Activity at time of fall ☐
- Feeling unwell ☐
- Environmental hazards ☐
- Wearing glasses ☐
- Adequate lighting ☐
- Medication (forgotten/side effects) ☐
- Footwear ☐
- Eating drinking well ☐
- Intake of alcohol ☐
- Coordination – blackout – dizziness ☐
- Balance - Walking aid ☐

Are you developing a fear of falling? Yes ☐ No ☐

## Memory

Have you been more forgetful in the last 12 months to the extent that it has significantly affected your daily life?

Yes ☐ No ☐ (If yes please complete further memory questions from health section below)

### Accessing Dental Care

Have you seen a dentist in the last 2 years? Yes ☐ No ☐

If no, why have you not seen a dentist in the last 2 years?

Not needed too	<input type="checkbox"/>
Couldn't find a dentist	<input type="checkbox"/>
Dentists not taking any more patients	<input type="checkbox"/>
Too scared	<input type="checkbox"/>
Cost	<input type="checkbox"/>
Transport	<input type="checkbox"/>
Managed by medication	<input type="checkbox"/>
Mobility problems	<input type="checkbox"/>
Other	<input type="checkbox"/>

Any other comments

### House and Home

Have you ever had an accidental fire in your home? Yes ☐ No ☐

Do you have a smoke alarm fitted in your home? Yes ☐ No ☐

### Carers Support

I the client care for someone else	<input type="checkbox"/>
I have a carer who cares for me	<input type="checkbox"/>

### Friends Family and People

Do you feel lonely or isolated? Yes ☐ No ☐

Reasons:

Loss of someone close to me ☐

Confidence ☐

Leaving workplace ☐

Disability or illness ☐

Other ☐

What do you think would help? (refer to hobbies and interest section)

**Follow on questions: please use questions below when a client scores 0-2 using the quality of life wheel**

## Health

### Physical Health

Do you feel your physical health is?

Good ☐

Varies ☐

Quite bad ☐

Very bad ☐

Have you been diagnosed with a physical health condition? Yes ☐ No ☐

Are you receiving support from services for your health condition? Yes ☐ No ☐

Any other comments

### Sleeping

Do you have trouble sleeping? Yes ☐ No ☐

Sleep Well ☐

Occasionally ☐

Always ☐

Why do you think you have trouble sleeping? (Refer to quality of life wheel)

- |                                     |                          |
|-------------------------------------|--------------------------|
| Health                              | <input type="checkbox"/> |
| House and Home                      | <input type="checkbox"/> |
| Managing Money                      | <input type="checkbox"/> |
| Communication                       | <input type="checkbox"/> |
| Friends, Family and People          | <input type="checkbox"/> |
| Emotional Well-being                | <input type="checkbox"/> |
| Personal care & Daily tasks         | <input type="checkbox"/> |
| Carer support                       | <input type="checkbox"/> |
| Volunteering and Work               | <input type="checkbox"/> |
| Hobbies & Interest                  | <input type="checkbox"/> |
| Getting out and about               | <input type="checkbox"/> |
| Managing and taking your medication | <input type="checkbox"/> |
| Other                               | <input type="checkbox"/> |

Any other comments

### Sexual Health

Do you have any concerns about your sexual health? Yes ☐ No ☐

Is your concern to do with?

- |                        |                          |
|------------------------|--------------------------|
| Sexual/Physical Health | <input type="checkbox"/> |
| Relationships          | <input type="checkbox"/> |
| Emotional Health       | <input type="checkbox"/> |

### Pain

Do you experience any pain? Yes ☐ No ☐

Where is the pain?

- |       |                          |            |                          |
|-------|--------------------------|------------|--------------------------|
| Head  | <input type="checkbox"/> | Upper back | <input type="checkbox"/> |
| Eyes  | <input type="checkbox"/> | Lower back | <input type="checkbox"/> |
| Nose  | <input type="checkbox"/> | Arms       | <input type="checkbox"/> |
| Mouth | <input type="checkbox"/> | Chest      | <input type="checkbox"/> |
| Ears  | <input type="checkbox"/> | Hands      | <input type="checkbox"/> |
| Teeth | <input type="checkbox"/> | Fingers    | <input type="checkbox"/> |
| Thigh | <input type="checkbox"/> | Neck       | <input type="checkbox"/> |

Legs ☐  
Feet ☐  
Bottom ☐  
Other ☐

What kind of pain is it?

Throbbing ☐  
Burning ☐  
Aching ☐  
Nagging ☐  
Shooting ☐  
Coping ☐  
Frightful ☐  
Unbearable ☐  
Nauseating ☐  
Stabbing ☐  
Spreading ☐  
Other ☐

Any other comments

## Breathing

Are you more breathless than friends or colleagues of a similar age to you? Yes ☐ No ☐

Do you get breathless doing everyday activities such as :

Walking alone the street at your own pace? Yes ☐ No ☐  
Climbing stairs Yes ☐ No ☐  
Dressing an undressing Yes ☐ No ☐  
Walking up an incline or hill Yes ☐ No ☐  
Washing and Drying Yes ☐ No ☐

Occasionally ☐  
At night ☐  
Day & night ☐  
Other (Please state)

When walking ☐  
During the day ☐  
On exertion ☐

Do you avoid doing certain activities altogether because they leave you feeling breathless? Yes ☐ No ☐

Have you got a diagnosed breathing problem? Yes ☐ No ☐

If you answer yes to any of the above, then it's time to do something about it.

- Visit your GP
- Speak to you British Lung Foundation respiratory nurses on 03000 030 555
- Visit [www.blf.org.uk/breathless](http://www.blf.org.uk/breathless) for more information

Any other comments

## Skin

Do you have any problems with your skin? Yes ☐ No ☐

Sore areas/red sore areas ☐  
 Wounds ☐  
 Bruising ☐  
 Rash ☐  
 Other (Please state) ☐

Any other comments

## Teeth

Are you having problems with your teeth? Yes ☐ No ☐

Pain ☐  
 Injury ☐  
 Eating and drinking ☐  
 Sensitive teeth ☐  
 Broken or chipped ☐  
 Dentures ☐  
 Redness or swelling ☐  
 Gum Problems ☐  
 Bleeding ☐  
 Other ☐

**Food & Health (Further questions following on from standard questions)**

## General Healthy Eating:

1. Do you have breakfast everyday?

Yes ☐ No ☒

If 'Yes' – What types of foods?

2. Do you eat some starchy carbohydrates at every meal? E.g. potatoes, rice, bread, pasta

Yes ☐ No ☒

3. Do you eat some portions of fruit & vegetables each day?

Yes ☐ No ☒ Sometimes ☒

4. Do you have any dairy products in your diet? E.g. milk, yoghurt, cheese

Yes ☐ No ☒ Sometimes ☒

5. Do you have any protein in your diet? E.g. meat, fish, eggs, beans, nuts, quorn

Yes ☐ No ☒ Sometimes ☒

6. Do you have much fat in your diet? E.g. oil, butter, crisps, pastry

Yes ☒ No ☐ Sometimes ☒

7. Do you have much sugar in your diet? E.g. in drinks, chocolate, sweets, cakes

Yes ☒ No ☐ Sometimes ☒

8. Do you cook with and/or add salt to your food?

Yes ☒ No ☐ Sometimes ☒

### Access & Cooking:

1. How confident are you at preparing/cooking meals for yourself?

Very confident ☐ Quite confident ☐ Unconfident ☒ Very unconfident ☒

2. Do you usually cook meals each day from scratch? E.g. using raw/fresh ingredients

Yes ☐ No ☒

3. Do you consume ready/microwave or takeaway meals?

Yes ☒ No ☐ Sometimes ☒

If 'Yes' or 'Sometimes' – How often?

4. How confident are you in planning and shopping for food?

Very confident ☐ Quite confident ☐ Unconfident ☒ Very unconfident ☒

5. How easy is it for you to access shops to buy food and drink? E.g. bus, walk, car

OK ☐ Good ☐ Poor ☒



### Nutrition:

1. Do you think you suffer from constipation?

Yes ☒ No ☐ Sometimes ☒

2. Do you have difficulties chewing/swallowing food and drinks? E.g. is it painful to chew?

No ☐ Yes - gets stuck ☐ Yes - sore mouth ☐ Yes – poor dentures ☐

Yes ☐ – Other:

3. Do you have a wound that is not healing or any pressure ulcers?

Yes ☐ No ☐

4. Do you take any vitamin supplements?

Yes ☐ No ☐

If 'Yes' – Which?

### Other:

In terms of additional support, would you be interested in either:

1:1's ☐ Groups ☐ Both ☐

Any other comments

### **Bladder & Bowel Control**

Do you experience any problems controlling your bladder? Yes ☐ No ☐

Occasional leakage ☐  
Leakage (day) ☐  
Leakage at all times ☐

Leakage (night) ☐  
Other (please state) ☐

Do you experience any problems controlling your bowels? Yes ☐ No ☐

Occasional leakage ☐  
Leakage (day) ☐

Leakage (night) ☐  
Other (please state) ☐

Leakage at all times ☐

In relation to the previous questions, have you been assessed previously?

Yes ☐ No ☐

Yes, it's been less than three months ☐

Yes, it's been more than three months ☐

No, never been assessed ☐

How are you managing at the moment?

Incontinence pads- I/carers buy my own ☐

Incontinent pads- these are provided for me ☐

I am not coping ☐

Support from carer/family ☐

Any other comments

**Memory (if client answered yes in the standard memory question, please complete the questions below)**

If yes how often?

Occasionally ☐

Getting worse ☐

Other ☐

How does this have an impact on your day to day life? (Please tick those that apply)

Forgetting important tasks ☐

Forgetting appointments/dates ☐

Going out ☐

Managing your money ☐

Forgetting to take medications ☐

Ability to communicate ☐

Impact on cooking ☐

Feeling lonely ☐

Loss of choice & decision making ☐

Losing things ☐

Other ☐



## Phq-2-gad-2 screening

### Note:-

Only Use Phq-2-gad-2 screening, if you are unsure where to send the client for support.. This screening is mainly used for clinical depression.

	Over the last 2 weeks(or other agreed period) how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Feeling nervous, anxious or on edge	0	1	2	3
4	Note being able to stop or control worrying	0	1	2	3

- Questions 1 & 2 screen for depression, with a total score of 3 or more for these two items suggesting the strong possibility of clinical depression.
- Questions 3 & 4 screen for anxiety (GAD, panic, PTSD & social anxiety), with a total score of 3 or more for these two items suggesting the strong possibility of clinical anxiety.

### References:-

Kroenke, K., R. L. Spitzer, et al. (2003). "The Patient Health Questionnaire-2: validity of a two-item depression screener." Med Care 41(11): 1284-1292.

Kroenke, K., R. L. Spitzer, et al. (2007). "Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection." Ann Intern Med 146(5): 317-325.

## Communication

How do you view your ability in relation to the following?

Talking

Do you struggle talking?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you struggle to find the right words?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your talking sound different (e.g. slurred speech)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this a new problem or longstanding problem?	New <input type="checkbox"/>	Old <input type="checkbox"/>
Have you or do you see a speech and language Therapist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any other comments

## Understanding others

Do you find it difficult understanding others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you find it difficult to answer questions when asked	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this a new problem or longstanding problem?	New <input type="checkbox"/>	Old <input type="checkbox"/>
Have you or do you see a speech and language Therapist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any other comments

## Hearing

	Yes	No
Do people seem to be mumbling?		
Do you have to strain to hear when someone talks or whispers?		
Do you have difficulties hearing someone call you from behind or from another room?		
Do you need to watch a speaker's lips more closely to follow the conversation?		
Do you find it hard to keep up in meetings, in restaurants, or in lectures?		
Do you have to turn up the volume on the TV or radio?		
Do you find it hard to hear clearly on the telephone?		
Do you have difficulties hearing at the theatre, cinema or other entertainment venues?		
Do you find it hard to hear in noisy environments like in the street or in a car?		
Do you tend to limit your social activities because it's difficult to hear and communicate?		
Do family, friends, or colleagues mention that they often have to repeat themselves?		

Any other comments

## Reading and Writing

Do struggle to read or write	Yes <input type="checkbox"/> (Please tick below)	No <input type="checkbox"/>
Do you struggle to see the words	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you struggle to hold a pen	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this a new problem or longstanding problem?	Old <input type="checkbox"/>	New <input type="checkbox"/>
Is this from difficulty from childhood	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you or do you see a speech and language Therapist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any other comments

## Swallowing

Do you find it difficult to swallow food and drinks?	Yes <input type="checkbox"/> (Please tick below)	No <input type="checkbox"/>
Do you cough when you eat & drink	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, how often do you cough	Every time I eat/drink <input type="checkbox"/> Once per day <input type="checkbox"/> Once per week <input type="checkbox"/> Not often <input type="checkbox"/>	
Is this a new problem or longstanding problem?	New <input type="checkbox"/>	Old <input type="checkbox"/>
Do you suffer from regular chest infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you or do you see a speech and language Therapist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any other comments

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## Seeing

Do you have concerns about your eyesight	Yes <input type="checkbox"/> (Please tick below)	No <input type="checkbox"/>
Do you struggle to see things that are far?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you struggle to see things that are near	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is this a new problem or longstanding problem?	New <input type="checkbox"/>	Old <input type="checkbox"/>
Have you seen anyone about this?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had an eye test in the last 2 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any other comments
--------------------

## Personal Care & Daily Task

In your day to day activities, do you have any difficulties with any of the following?

	Yes	No	Fine with help
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
food and drink (Preparing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying out household tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments
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## Getting out and about

In your day to day activities, do you have any difficulties with any of the following?

	Yes	No	Fine with help
Walking indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up/down the stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving from Chair to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visiting shops, banks/post Office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments

## Managing and Taking your Medication

What are your main concerns in managing and taking your medication (Please tick below)

Remove packaging	<input type="checkbox"/>
Reading labels	<input type="checkbox"/>
Using equipment/aids	<input type="checkbox"/>
Taking the right dose at the right time	<input type="checkbox"/>
Swallowing tablets/liquids	<input type="checkbox"/> (Are you able to swallow food drink? Yes/No)
Storing and/or display of safely	<input type="checkbox"/>
Ordering & collecting your medication	<input type="checkbox"/>

Do you take your medication as advised?      Yes ☐      No ☐ (Please tick that apply)

Not effective	<input type="checkbox"/>
Side effects	<input type="checkbox"/>
Unsure of reason	<input type="checkbox"/>
Confused/ mixed up	<input type="checkbox"/>
Unable to collect	<input type="checkbox"/>
I forget to	<input type="checkbox"/>
Other	<input type="checkbox"/>

Any other comments

**Family Friends and People**

Do you speak to or see family & friends as often as you like to?

Yes ☐      No ☐      Reason \_\_\_\_\_

Are there people you can rely on to help if you had a problem?

Yes ☐      No ☐      Reason \_\_\_\_\_

Are you happy with the relationships you have with family & friends or others?

Yes ☐      No ☐

I don't feel like am able to trust others	<input type="checkbox"/>
They make me feel loved	<input type="checkbox"/>
I don't want to bother them	<input type="checkbox"/>
They accept me for who I am	<input type="checkbox"/>
They have very little time for me	<input type="checkbox"/>
They give me support and encouragement	<input type="checkbox"/>
They would see that I am taken care of, if I needed to be	<input type="checkbox"/>
Other	<input type="checkbox"/>

Do you look after any pets? Yes ☐ No ☐

If yes, are any of the following a concern for you?

Looking after them	<input type="checkbox"/>
Cleaning up after them	<input type="checkbox"/>
Taking them for a walk	<input type="checkbox"/>
Feeding them	<input type="checkbox"/>
Other	<input type="checkbox"/>

Do you have any concerns about sexual relationships? Yes ☐ No ☐

Any other comments

## Hobbies & Interest

Do you take part in hobbies/interest?    Yes   ☐                      No   ☐ (Please state)

If no, what stops you from taking part in hobbies/interest?

- Illness ☐
- Time ☐
- Lack social support ☐
- Access ☐
- Age ☐
- Religious/Culture ☐
- Transport ☐
- Cost ☐
- Suitable activities for me ☐
- Confidence ☐
- Safety ☐
- Lack of information ☐
- Other (Please state) ☐

What hobbies/interests would you like to take part in?

- Religious & faith groups ☐
- Knitting & sewing ☐
- Physical activity & exercise ☐
- Arts/Craft ☐
- Cooking ☐
- Shopping ☐
- Eating out ☐
- Games ☐
- Puzzles/Crosswords ☐
- Gardening ☐
- Cinema/Bingo ☐
- Listening to music ☐
- Reading & writing ☐
- Visiting family/friends ☐
- Going on Holiday ☐
- Luncheon Clubs ☐
- Other ☐
- Befriending groups ☐
- Self Help groups ☐
- Mutual support groups ☐

Any other comments

## Volunteering/Work

Do you carry out any type of volunteering activities/employment?

Yes ☐ (Please state below)

No ☐

Type

Hours worked

Volunteering activities ☐

\_\_\_\_\_

Paid employment ☐

\_\_\_\_\_

Self employed ☐

\_\_\_\_\_

Do you have any concerns regards to volunteering/work?

Yes ☐ Please state

No ☐

Volunteering

Work

Hours of work

☐☐

Job role & capacity

☐☐

Work/life balance

☐☐

Restrictions due to physical health

☐☐

Stress

☐☐

Skills

☐☐

Age

☐☐

Lack of information/knowledge

☐☐

IT Skills

☐☐

Other

☐☐

Would you like further information/support on volunteering? Yes ☐ No ☐

Would you like further information/support on employment? Yes ☐ No ☐

Have you applied for a volunteering opportunity before? Yes ☐ No ☐

If yes, please state outcome

Any other comments

## House and Home

What type of property/accommodation do you live in?

- Social rented ☐  
 Private rented ☐  
 Owner occupied with mortgage ☐  
 Owner occupied without mortgage ☐  
 Living rent free with family ☐  
 Living rent free with other (please state) ☐

Do you live with others? Yes ☐ No ☐

How many	Their relationship to you.

Do you look after any pets? Yes ☐ No ☐

If yes, are any of the following a concern for you?

- Looking after them ☐  
 Cleaning up after them ☐  
 Taking them for a walk ☐  
 Feeding them ☐  
 Other ☐

Have you any concerns about living arrangements in your house/home?

Yes ☐ No ☐

- Can you easily access and get around your home? ☐ ☐  
 Would you benefit from any adaptations being made to your home? ☐ ☐  
 Do you need help making repairs and improvements to your home? ☐ ☐  
 Does your home suffer from damp or mould? ☐ ☐  
 Can you keep your home warm? ☐ ☐  
 Are you able to manage your housing costs? ☐ ☐  
 Have you thought about what your housing requirements might be in the future? ☐ ☐

Any other comments

## Managing your Money

What are your main concerns regarding your finance or ability to manage your money?

	Yes (Reason)	No
Change in circumstances	<input type="checkbox"/>	<input type="checkbox"/>
Buy necessities	<input type="checkbox"/>	<input type="checkbox"/>
Paying household bills	<input type="checkbox"/>	<input type="checkbox"/>
Housing costs	<input type="checkbox"/>	<input type="checkbox"/>
Involvement of others	<input type="checkbox"/>	<input type="checkbox"/>
Trusting people/organisations	<input type="checkbox"/>	<input type="checkbox"/>
Lack of information	<input type="checkbox"/>	<input type="checkbox"/>
Having to borrow money	<input type="checkbox"/>	<input type="checkbox"/>
Benefit entitlement	<input type="checkbox"/>	<input type="checkbox"/>
Budgeting	<input type="checkbox"/>	<input type="checkbox"/>
Power of Attorney	<input type="checkbox"/>	<input type="checkbox"/>
Repaying debts	<input type="checkbox"/>	<input type="checkbox"/>
Heating cost	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Any other comments

## Feeling Safe

Do you feel safe in your home? Yes ☐ No ☐  
Do you feel safe out doors? Yes ☐ No ☐

If no, what is causing you to feel unsafe?


Nuisance neighbours	<input type="checkbox"/>
Abandoned cars	<input type="checkbox"/>
Vandalism	<input type="checkbox"/>
Graffiti	<input type="checkbox"/>
Drunken or rowdy behaviour	<input type="checkbox"/>
Harassment/intimidation/threats.	<input type="checkbox"/>
Burglaries in your neighbourhood	<input type="checkbox"/>

Bogus Callers  
 Pressurized doorstep selling  
 Rogue traders  
 Other

☐  
☐  
☐  
☐

Comments

### FREE Carers Fact-Sheets – Order Form

Number	Title	Yes I want a copy Please 
1	New to Caring	
2	Carers Assessments	
3	Financial Help and Support	
4	Hospital Discharge	
5	Working and Caring	
6	Transport	
7	Emotional Support	
8	Education and Leisure	
9	Bereavement - When Caring Ends	
10	How to Complain	
11	Emergencies	
12	Meals	
13	DIY / Gardening / Practical Support	
14	Stroke	
15	Parkinson's Disease	
16	Dementia	
17	Luncheon Clubs and Community Cafe's	
18	Aids, Adaptations and Equipment	
19	Finding and Paying for Care through a Private Agency	
20	Caring for a Child with a Disability	
21	Watch Your Back	
22	Getting the most from your GP	
23	Cancer	
24	Wheelchairs	
25	Technology can help you care	
26	Wills and Trusts	
27	Falls	



<b>28</b>	Get Active	
<b>29</b>	Look after your heart	
<b>30</b>	Dealing with debt	
<b>31</b>	Multiple Sclerosis	
<b>32</b>	Raising Funds for Bolton Carers Support	
<b>33</b>	Visual Impairment	

## Algorithms

Algorithms form part of the toolkit to identify appropriate support and services for the client. An example of one of the algorithms for “house and home section” has been included in this product. Developing the algorithms would very much be dependent on the service provision available in your geographical area, hence would have to be developed locally.

The algorithms have particular been useful in targeting and tailoring appropriate support to individual needs and taking the following into consideration:-

- Eligibility criteria's
- Referral and access pathways
- Key contacts details

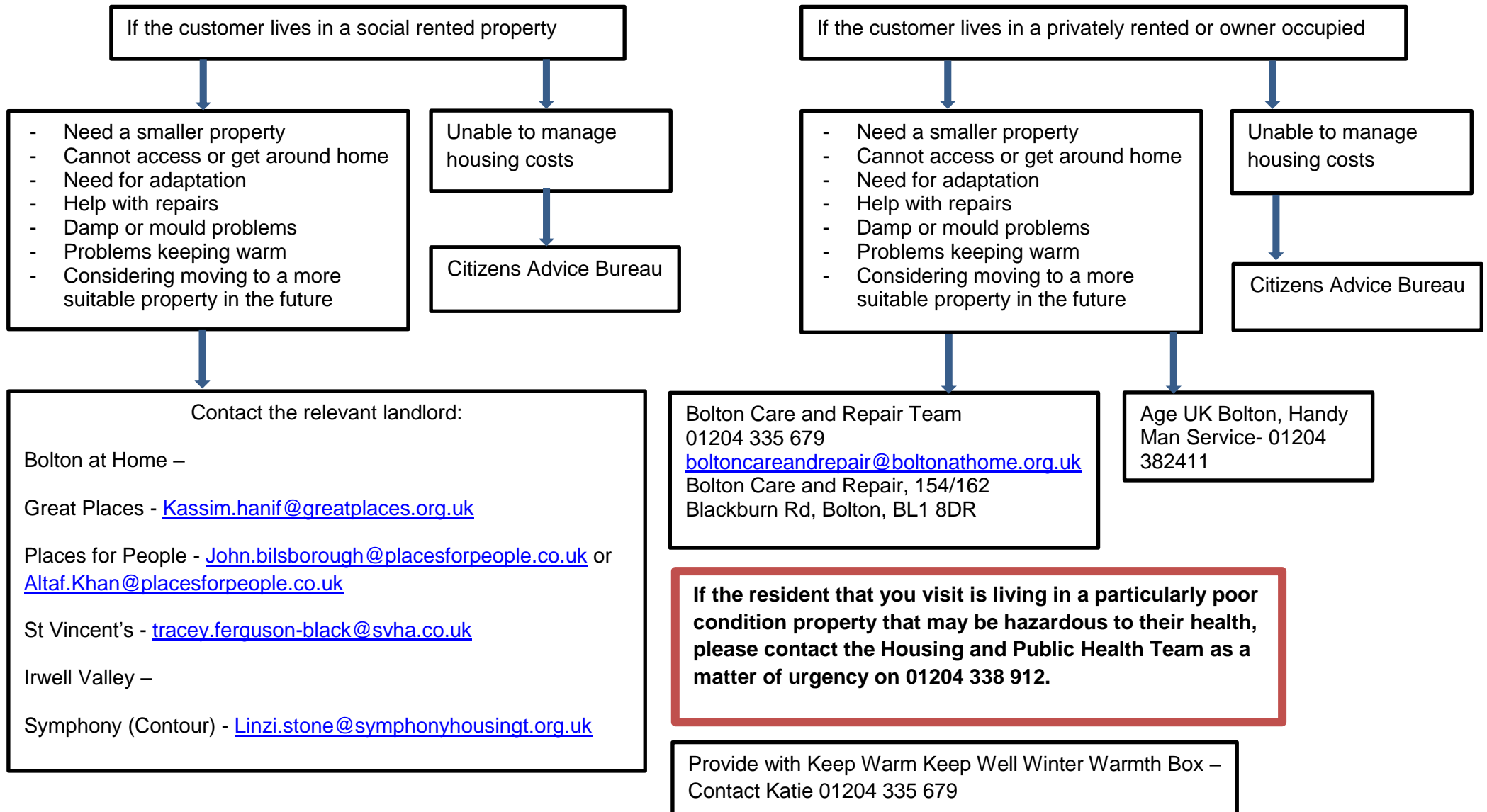
For the purpose of the service, the Staying Well Team would ensure the algorithms are updated as and when a change in service provision occurs.

Overall the algorithms support the following:-

- Resource of information and services to hand
- Effectively and timely source appropriate information, advice & support
- Opportunity to identify gaps in service provision

- Not an exhaustive list, but a base of information to build on and update as and when

## House and Home Actions



## **Staying Well Visit Summary Information**

The purpose of the visit summary is to record the findings from the home visit. The summary details the following:-

- Summary of support identified
- What's going well (assets)
- What's going less well (needs)
- Any observations by the Co-ordinator
- Action and next steps for the Co-ordinator
- Actions and next steps for the client
- Action and next steps for the GP Practice/onward service provider/organisation
- Sign off progress update

Once a home visit has been completed the Staying Well Co-ordinator would write up a summary of the visit within 24 hours following the visit. A copy is then sent to the client and the GP Practice to be scanned into the clients records. A copy is also kept for the purpose of the project.

Overall the Staying Well Visit Summary supports:-

- Summarises and records overall visit and actions agreed
- Useful information for services/organisations when referring clients
- Client has their own record and kept in the loop
- GP's have access to information and outcome of the visit

## Staying Well Visit Summary Information

<b>Patient ID</b>		<b>Date of visit</b>	
<b>Patient Name:</b>		<b>Carer's Name &amp; Contact)</b>	
<b>Address:</b>			
<b>Patient email:</b>		<b>Patient Telephone</b>	
<b>Co-ordinator name</b>		<b>Practice ID</b>	
<b>Co-ordinators Signature:</b>		<b>D.OB</b>	
<b>Language Spoken:</b>		<b>Interpreter required:</b>	

During our visit we jointly identified some support in relation to the following areas:

Health <input type="checkbox"/>	House & Home <input type="checkbox"/>	Managing your Medication <input type="checkbox"/>
Emotional well-being <input type="checkbox"/>	Friends, family and People <input type="checkbox"/>	Getting out and about <input type="checkbox"/>
Personal care and daily Tasks <input type="checkbox"/>	Hobbies & Interest <input type="checkbox"/>	Communication <input type="checkbox"/>
Managing your money <input type="checkbox"/>		Volunteering and work <input type="checkbox"/>
Carer support <input type="checkbox"/>		

<b>Summary of support identified: (Client Perspective)</b>
<b>What's going well?</b>
Health
Carer Support
Emotional Well-being
Getting out and about
Personal Care and Daily Tasks
House and Home
Managing Money
Friends Family and People
Communication
Volunteering and Work
Hobbies and Interests
Managing Medication
<b>What's going less well?</b>
Health
Carer Support
Emotional Well-being

Getting out and about		
Personal Care and Daily Tasks		
House and Home		
Managing Money		
Friends Family and People		
Communication		
Volunteering and Work		
Hobbies and Interests		
Managing Medication		
<b>Co-ordinators Observation</b>		
<b>Actions and next steps for the Staying Well Co-ordinator</b>	<b>Date Completed: SWC.</b>	<b>Date Completed: Client.</b>
Health		
Carer Support		
Emotional Wellbeing		
Getting Out and About		
Personal Care and Daily Tasks		
House and Home		
Managing Money		
Friends, Family and People		
Communication		
Volunteering and Work		
Hobbies and Interest		
Managing Medication		
<b>Actions and next steps for the Client</b>	<b>Date Completed: Client.</b>	

Health	
Carer Support	
Emotional Wellbeing	
Getting Out and About	
Personal Care and Daily Tasks	
House and Home	
Managing Money	
Friends, Family and People	
Communication	
Volunteering and Work	
Hobbies and Interest	
Managing Medication	
<b>Actions and next steps for the GP Practice/Service Provider Organisation</b>	<b>Date Completed:</b>
Carer Support	
Communications	
Personal Care and Daily Tasks	
Managing Money	
House and Home	
Friends Family and People	
Hobbies and Interest	
Getting out and about	
Managing and taking your medication	
Volunteering & Work	
Health	
Emotional Well-being	

With your consent a copy of this summary will be automatically sent to your GP and services involved in your care, providing you with appropriate support, advice and information. A copy will also be sent to you for your records.

Sign off information	
Client sign off date	
Date	Progress update
	Comments/other actions/considerations



# StayingWell

thinking today for tomorrow

Helping you to get the  
right support at the right  
time to remain healthy,  
happy and independent.

