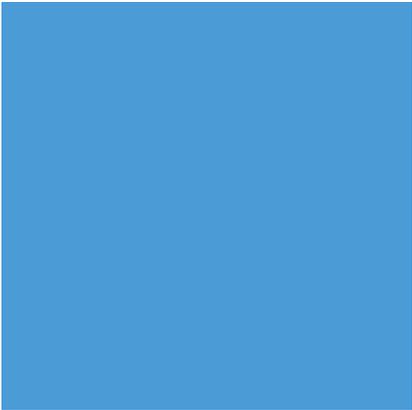
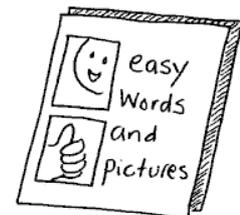


Preferred Place of Care (Accessible Version)



Preferred Place of Care

- It's important that people have a choice of where they receive care and support when they are coming to the end of their life.
- This plan is a record of the choices made by you about the place of care and support you might want when coming to the end of your life.
- This plan can be completed by you and other sections will be completed by people who support you.
- You will be asked for details about your home. This will help the people supporting you to complete your plan.
- The plan will tell people how you communicate which will help others to support you better.
- The plan will be a record of your choices. If changes have to be made to your choices this will be recorded in your plan.
- Should you need any help in completing any parts of the plan please ask your nurse or carer for help



Preferred Place of Care



Name:

Address:.....

.....

.....Post Code:.....



Tel:  Mobile: 

NHS No:.....

Confidentiality

- Your information will be kept on our computer. We will also keep written records to check where your care and support is given.
- Any information you give will remain private to protect you.
- Your information will only be given to other people with your agreement.
- Your information will be held in safe place and will be for people who need to know about it.



Please

Leave

Blank

Preferred Place of Care Plan

Male/Female	Date of birth	Doctor	Postcode

Ethnicity – completion optional (please tick appropriate box) ✓									
White	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>	Other Asian	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Black African	<input type="checkbox"/>	Black Other	<input type="checkbox"/>	Other	<input type="checkbox"/>
Language spoken – if English is not the first language									

Was the preferred place of care achieved? Yes No

Place Date:

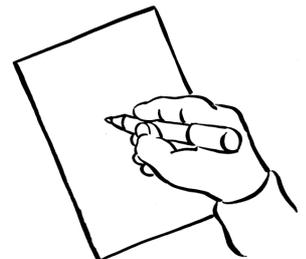
Would personnel completing this plan please complete their details below

Name (please print)	Signature	Title/Profession	Workplace	Date

This plan is to be kept by the person at their home and should follow the person if admitted to another place of care i.e. hospice or hospital.



This plan is to be completed as part of the assessment using, where possible, the persons own words. (Where there are communication difficulties and family, friends or support staff may be consulted).



Home Situation (to be completed at initial assessment)

Describe the current living situation



Support networks available from family, friends or others

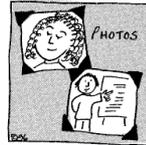


Family/friend or support staff needs



Marital Status (tick box)	Dependants	Main carer(s) (tick box)
Single <input type="checkbox"/>		Family <input type="checkbox"/>
Married <input type="checkbox"/>		Friend <input type="checkbox"/>
Living with partner <input type="checkbox"/>		Support Staff <input type="checkbox"/>
Widowed <input type="checkbox"/>		
Divorced <input type="checkbox"/>		
Separated <input type="checkbox"/>		

Communication:



The person communicates by using:	Tick	Other Comments
1. Speech.		
2. Pictures, photos, symbols.		
3. Signing system (i.e. Makaton, BSL, etc).		
4. Own gestures.		
5. Action, behaviour etc.		
6. Noises, vocalisations etc.		
7. Objects (e.g. bringing coat to say I want to go out).		
8. Use Information Technology equipment.		
	Circle	
		Other Comments
Has it been identified anywhere that the person has difficulty in understanding words that are spoken to them?	Yes	No
Does the person have a communication Dictionary or Passport to aid communication?	Yes	No
Does the person read?	Yes	No
Is there Speech & Language Therapy involvement with the service user?	Yes	No

Support and Care Plan.

- Whilst you have been ill what has been happening to you?



Family, friends or support staff view.



- What's important **to** you? What would you like or not like to happen?



What's important **for** you? (Family, friends or support staff views, what needs to be in place to keep person keep health & safe?)



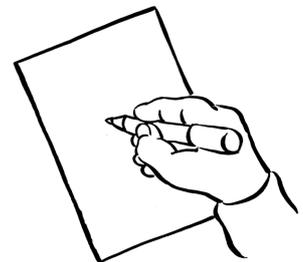
- Place of Care – Choices



Family, friends or support staff view.



Additional notes or considerations.

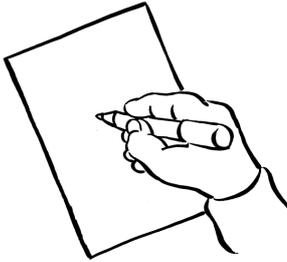


Best Interest Discussion

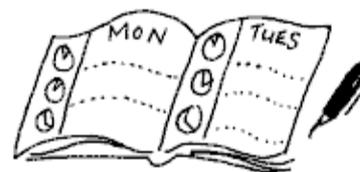


Were pages 8 and 9 completed as part of a best interest discussion.	Yes	No
---	-----	----

If yes, who was involved in the discussion? (Print name and title).	

<p>Additional notes</p> <div style="text-align: right;">  </div>

Date Initiated: If the person's wishes or feelings change please record and date these changes on the next page.



Review Dates				

This form records any changes to what was agreed on pages 8 and 9



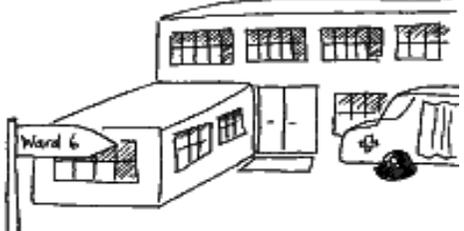
Date and time	What changes and why?	What action was taken?	Carers comments	Signature of Health-care Professional	Name (please print)

This form records any changes to what was agreed on pages 8 and 9



Date and time	What changes and why?	What action was taken?	Carers comments	Signature of Health-care Professional	Name (please print)

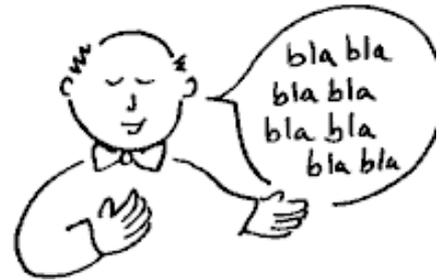
Complete the table below as soon as a person is diagnosed. When the person uses new or different services, fill in the Change in Care Sheet (Page 10 & 11) and ensure that the document goes with the person. (The person, carer, support staff or Health Care Professional can complete this page)

	Services available locally (please tick)		Services currently Being accessed (please tick)		Date referred	Date of admission/attendance/ receipt of services	Date discharged
	Yes ✓	No ✓	Yes ✓	No ✓			
Hospital <ul style="list-style-type: none"> • In-patient • Out-patient 							
Hospice <ul style="list-style-type: none"> • In-person • At home • Day Care • Respite Care 							
Care Home							
<ul style="list-style-type: none"> • Social Services/Care Agencies • Social Worker • Specialist Palliative Care Social Worker 							

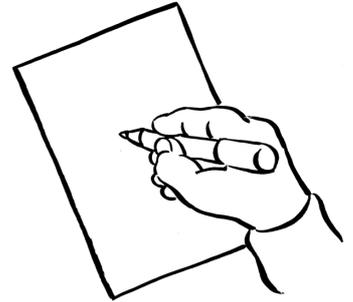
	Services available locally (please tick)		Services currently Being accessed (please tick)		Date referred	Date of admission/attendance/ receipt of services	Date discharged
	Yes ✓	No ✓	Yes ✓	No ✓			
District Nurse availability (hr available...) • Daytime..... • Evening..... • 24 hr.....							
Marie Curie service • Daytime..... • Evening..... • 24 hr.....							
Specialist Nurse – please specify: e.g. Community Matrons, Macmillan/ Admiral Nurse, other specialist nurses or professionals.							
GP Name.....							

	Services available locally (please tick)		Services currently Being accessed (please tick)		Date referred	Date of admission/attendance/ receipt of services	Date discharged
	Yes ✓	No ✓	Yes ✓	No ✓			
<ul style="list-style-type: none"> • Allied Health Professionals • Physiotherapy • Occupational Therapist • Dietician • Podiatrist/Chiropodist • Speech & Language Specialist 							
Support System e.g. Multi-Faith Chaplains/PALS, Counsellors (please specify)							
Access to other support services e.g. Complementary Services, other specialist services, befriending schemes, self-help groups, religious groups							
Comments (e.g. if services are available and are easy to get to)							

We would like to hear any comments you have on the provision of the care and support you are receiving, and any services that are available.



Your Notes



Information

Next of Kin/Main Carer:.....

.....Tel. No 



Doctor:.....

.....Tel. No 



District Nurse:.....

.....Tel. No 



Specialist Nurse/AHP/LD:.....

.....Tel. No 

Primary Care Trust contact address:.....

.....

.....Tel. No 

Or the Local Hospital address if different:

.....Tel. No 

Other:.....

.....

.....



Preferred Place of Care (accessible version)

Originated by Lancashire and South Cumbria Cancer Services Network
accessible version adapted by Calderstones NHS Trust

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Room 213
Preston Business Centre
Watling Street Road
Fulwood
Preston
PR2 8DY

Preferred Place of Care (accessible version)