Less admin **more care**…

... a comprehensive care planning system, easy for staff to use … it promotes the opportunity to ensure that all care plans are individualised and person centred. During the last three inspections **CQC** were happy with every one of our care plans … the nurse assessors from the local PCT have commented about the high quality of our care plans and that all of the information they require is accurately recorded and easy to find. The documentation guide helps staff to understand the relevance of each form and how each can be used to evidence that the outcomes are being met …

Jo Turner (Manager) Chester Lodge

Comprehensive Care Planning System

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Company Overview

Standex Systems have been providing care planning systems to the care sector for over 40 years. Part of an international group with over 18,000 satisfied clients which includes 2,500 in the UK alone. Standex in the UK specialise in providing care planning systems to care homes, nursing homes, hospices and hospitals.

At Standex Systems Ltd we always strive to be ahead of your documentation needs. By keeping a close eye on the requirements of the Care Quality Commission, we are able to develop and update care planning systems in line with the regulations. As a company we provide a wide range of filing and storage solutions to compliment our care planning system to create a one stop shop for your care planning needs.

Other product ranges available:
- Files & Storage
- Waste & Laundry
- Treatment Trolleys
- Medication Trolleys

Fax: 01604 644 646 Web: www.standexsystems.co.uk
Thank you for your interest in Standex Systems Care Planning Documentation. We design, develop and implement care planning documentation for care homes and domiciliary care settings. Lucy Caldwell (RGN) is our Nurse Advisor and ensures that all the documentation is up to date, evidence-based and in line with the requirements of the Care Quality Commission (CQC) and Local Authorities (LA). She also provides ongoing support and advice for all our customers.

For further details and to arrange a no-obligation quote please contact us on: 01604 646 633

Some of the products that we produce:

- **Care Home Care Planning System** – All assessments including holistic, mental capacity and deprivation of liberty along with all mandatory and risk assessments. Person centred care planning (including advanced care planning for end of life), evaluation and reports. The system allows staff to evidence that they are meeting all CQC and LA requirements. See below for an example.
- **Care Planning Handbook** – An introduction to care planning with prompts for the need, goal and support required for each activity of daily living. Includes examples of how to write a care plan for each activity and a guide to how you should assess for mental capacity and deprivation of liberty. See below for information.
- **Documentation Guide** – A comprehensive guide explaining each form in depth.
- **Training** – Training sessions on how to use the care planning system correctly and to its full potential.
- **Audit Tool** – Enables staff to identify forms within a service user care plan being filled out incorrectly, missing or used inappropriately together with actions required to achieve excellent care planning. In line with CQC audit requirements.
- **Domiciliary Care Planning System** – Holistic assessments; mandatory assessments and risk assessments (inside and outside the home). Person centred care planning for each visit, evaluation and reports. Allows staff to evidence that they are meeting all CQC and LA requirements.
- **Files** – To store all the service user’s documents in one place
- **Storage** – Many storage solutions including lockable trolleys to securely store each service user file

**Standex Systems products are:**

- Cost effective
- Fully compliant
- Up to date and evidence based
- In line with best practice
- In line with the requirements of the Care Quality Commission and Local Authorities

"...a comprehensive care planning system, easy for staff to use...it promotes the opportunity to ensure that all care plans are individualised and person centred. During the last three inspections CQC were happy with every one of our care plans…. the nurse assessors from the local PCT have commented about the high quality of our care plans and that all of the information they require is accurately recorded and easy to find..."

Jo Turner (Manager) Chester Lodge

Email: info@standexsystems.co.uk  Phone: 01604 646 633
Name:                                                               Date of Birth:                                                        Room Number:

Care Plan

Date Assessment of Need Review signature(s)
1/5/14 Tom has dementia and sometimes becomes confused due to this. This can affect his capacity to make decisions regarding day to day activities.
Tom says he often feels more confused in the mornings, however in the afternoon he is less confused.

Sue Smith (S. SMITH)

Goal/Expected Outcomes
1/5/14 Tom would like to be involved in all decision making where possible regarding his care. He wishes to be as independent as possible and should he not have capacity to make a decision at a particular time, and this decision cannot wait, then he wishes his daughter (who has written Lasting Power of Attorney) to be contacted.

Sue Smith (S. SMITH)

Note: All support required, focusing on what Tom can do to remain as independent as possible, is then recorded overleaf.

Nursing Care Plan

1. Mental Capacity
2. Washing & Dressing
3. Mobility
4. Sleeping/Night Care
5. Medication
6. Spirituality
7. 
8. 
9. 
10. 
11. 
12. 

Note: Each care plan sits on top of the other. These tabs are cut to give a quick reference guide to all the care plans required for that particular service user.

CARE PLAN

ACTIVITY PLAN
SOCIAL ACTIVITY

PERSONAL HISTORY
SUPPORT NETWORK
MENTAL CAPACITY ASSESSMENT
DEPRIVATION OF LIBERTY
LASTING POWER OF ATTORNEY
FUTURE WISHES

PERSONAL CARE
BOWEL CHART
FOOD CHART
WEIGHT CHART
BODY CHART

MANUAL HANDLING
FALLS RISK ASSESSMENT
MUST TOOL
INFECTION RISK ASSESSMENT
PRESSURE ULCER ASSESSMENT
BEDRAL RISK ASSESSMENT

MEDICATION RECORD
OBSERVATIONS & MONITORING
DIABETIC CHART
FLUID BALANCE
REPOSITIONING CHART
CATHERETER CHARGE

KEY WORKER NOTES
COMMUNICATION SHEET
MULTIDISCIPLINARY NOTES
DOCTORS NOTES
FAMILY COMMUNICATION
DISTRICT NURSE NOTES

STAFF SIGN SHEET
DAILY REPORT

REVIEWS
DEPENDENCY PROFILE
DEPRESSION SCALE

WOUND CHART
RECORD OF BEHAVIOUR
ORAL ASSESSMENT TOOL
EPILEPSY CHART
PRESSURE TEXAS CHART
PAIN CHART

DOCUMENTATION FILING STORAGE ACCESSORIES OTHERS

RESPITE
ADMISSION ASSESSMENT & CARE PLANNING
DEMENTIA & MENTAL CAPACITY INFORMATION
DAY TO DAY RECORDING
MANDATORY ASSESSMENTS/RECORDS
OPTIONAL NURSING INFORMATION
DAILY REPORTING & COMMUNICATION
DOMICILIARY CARE

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Interesting news, services and healthcare solutions waiting for you.

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Order our care home documentation fast and easily online with Standex Systems.
This easy to use care planning handbook offers a step by step guide to care planning for nurses and carers.

The handbook explains what a care plan is and why they are so integral to the delivery of excellent care within the home.

It looks at:

- What is a care plan?
- Mental capacity and care planning.
- Lasting Power of Attorney (LPA) and Deputies.
- Deprivation of Liberty Safeguards (DoLS).
- The care planning process.
- Elements of a good care plan.
- Elements of a poor care plan.

Prompts are given for the need, goal and interaction required in each care plan along with an example of how to write a care plan for each of the following areas:

- Mental Capacity and Cognition.
- Communication.
- Psychological Well being.
- Mobility and Falls.
- Washing and Dressing.
- Eating and drinking.
- Continence.
- Personal Safety and Risk.
- Breathing.
- Skin.
- Pain.
- Infection Risk.
- Medication and Symptom Control.
- Sleeping and Nightcare.
- Social Activities.
- Final Days.
Washing and Dressing Care Plan

Need

- Is the service user able to look their hygiene? (e.g. nails, teeth, hair, mouthcare).
- Is the service user able to dress themselves?
- Is the service user able to manage zips, buttons, laces etc?
- Does the service user have their own teeth?
- Does the service user wear dentures?
- Are the dentures correctly fitted?
- Does the service user need to see a Chiropodist/Dentist/Podiatrist?
- Does the service user have any problems with their feet? e.g. dry skin, bunions, diabetic ulcers, swelling etc.
- Any special footwear required?

Goal

- For all personal hygiene needs to be met whilst receiving the support required to maintain as much independence as possible?
- For all dressing needs to be met whilst receiving the support required to maintain as much independence as possible?

Support and Interactions

- Does the service user require a Personal Care Chart?
- Does the service user require an Oral Assessment (see Oral Assessment Tool)?
- What are their preferences? e.g. bath or shower?
- Does the service user prefer a male or female carer?
- What are the service users personal preferences with washing (e.g time of wash, favourite soap)?
- What assistance do they require?
- What can they do for themselves?
- Does the service user wish to have a daily shave?
- If the service user is totally dependent what can you do to ensure the bathroom is warm, inviting and secure?
- Can you talk through each activity using a calm tone and speaking slowly?
- What clothing preference does the service user have?
- What are the service users personal preferences with dressing (e.g time to dress, favourite clothes)?
- What is required to ensure the mouth is clean and fresh? e.g. checking daily, four hourly, assistance required etc.
- How often should the service user’s feet be checked? e.g. for broken skin.
- Does the service user require assistance with cutting toe nails?
- Are there any hazards associated with this area that need a General Risk Assessment?

Care Plan - Washing and Dressing

Assessment of Need

Tom has had a stroke and has weakness on his left side. He also has arthritis in his knees. As a result of this he finds it difficult to attend to his hygiene and dressing needs. He has difficulty getting in and out of the bath but prefers a bath to a shower. He also has difficulty in dressing especially with buttons and zips which he finds fiddly and he doesn’t always remember to do these up due to him sometimes being confused, so needs prompting and support from staff.

Goal/Expected Outcomes

Tom takes great pride in his appearance and it is very important to him to have all his hygiene needs met and to be dressed smartly during the day. He would like to remain as independent as possible.

Interactions and Support required

(including level of ability to engage)

In order to help Tom get in and out of the bath he needs to use a bath chair and will need the assistance of one carer to do this. Tom is able to wash himself however he sometimes needs prompting. For example if you give Tom a flannel and a simple clear sentence such as ‘you can use this to wash your face’ then Tom will respond and be able to wash his face on his own. He likes to wash his hair every other day and uses a mild shampoo. He doesn’t like aftershave but likes to use deodorant. Tom likes to dress himself but again may need prompting for ‘fiddly’ areas like zips and buttons. If he doesn’t have these prompts he will often forget and this may cause embarrassment which is a concern for Tom and his family. Tom likes to wear smart clothing including his army medals on a blazer. He likes to pin these on himself but may need some help with the smaller ones.

Daily Reporting, Care Plan Evaluation and Reviews

The handbook has a chapter on Daily Reporting and looks at the importance of recording in the correct manner:

- Examples of good practice.
- Examples of poor practice.
- Terminology to use and to avoid, with examples.

The handbook finishes with a look at Care Plan Evaluations and Reviews:

- Why the need for evaluating and reviewing.
- Acknowledging that care plans are always evolving.

Finally it explains the need for auditing of the care plans to ensure that all information is up to date within the care plans and that staff are recording effectively and in the correct manner.
21.049 Pre Assessment

- Demographics, medical history, medication, allergies, resus status.
- Holistic Assessment (including a section about whether service user has mental capacity at time of assessment).
- LPA details if applicable.
- Infection status.
- Reasons for acceptance/non acceptance.
- This form allows evidencing that the needs, wishes, preferences and decisions of the service user are placed at the centre of assessment, planning and delivery of care, treatment and support. Whilst promoting independence.
- The very first form that is used before the service user has even entered the home. It evidences that safe and appropriate care is given because individual needs are established from when they are referred. It can be recorded that all aspects of their individual circumstances, and their immediate needs are recorded prior to admission (or non admission as the case may be).
21.050 Re-Assessment

- A smaller version of Pre-Assessment to document any changes in service user’s condition on return to the home.
- Can document whether the home can still cater for service user’s needs.

21.026 Hospital Transfer Record

- Hospital Transfer Record should be used if the service user is taken into hospital.
- Provides ambulance crew and staff at the hospital with vital information regarding the service user’s health and support required.
- The principal concern of the care home is to maintain the service user’s well-being, provide optimal care during the transfer period, and to deliver the service user safely to the receiving unit.
- The care home can keep the top copy for their records, the 2nd and 3rd copies can be given to the hospital and ambulance crew for their records.
- You may attach photocopied care plans and the latest daily report if you feel this will better inform nursing staff of support required.

21.051 Admission

- Service user details on admission.
- Designed to go in front pocket of the file where it can be seen quickly and easily.
- Quick ‘at a glance’ view of service user’s details.
21.052 Support Plan

- Based on Roper, Logan and Tierney's Activities of Daily Living with further categories for a more robust assessment.
- Any problems trigger a care plan.
- This can be done on a monthly basis or more frequently if needs change. Here we have the review section where the service user/advocate can sign to say they have been involved in the assessment.
- The holistic assessment looks at Cognition, Psychological, Physical, Social and End of Life.
21.053 Care Plan

- Generated from the Support Plan.
- Looks at need, goal and support required.
- Each plan needs to be person-centred (blank for you to do this).
- Our Documentation Guide gives you prompts for each area and encourages staff to think in a ‘person-centred way’.
- There is a larger care plan available to sit at the back if preferred - 21.129

21.054 Care Plan Evaluation

- To be used to document the evaluation of the care plans.
- There is a larger care plan evaluation available to sit at the back if preferred - 21.130
21.055 Activity Plan
• To be used as the care plan but specifically for social activity.
• Useful for use by Social Activity Co-ordinators.

21.056 Activity Plan Evaluation
• To be used to document the evaluation of the activity plans.

21.057 Social Activity
• Can be used to plot dates of social activities.
• There is a year on a form.

21.058 Social Activity Comments
• Can be used to write comments about the social activity in conjunction with the activity care plans or on their own.
21.059 Personal History

- Personal Story.
- Useful for reminiscence, especially in those with dementia.
- Person-centred.

21.060 Support Network

- Quick glance document can be used to document service user's support.
- Can be used for any out of hours contacts such as Macmillan Nurse etc. Therefore supporting End of Life documentation.
21.061 Mental Capacity Assessment

- To be used if a service user needs to make a decision and their mental capacity is in question.
- Assists staff in assessing capacity in line with the Mental Capacity Act 2005.
- Details of action taken in service user’s best interests to be recorded on the reverse.

21.062 Deprivation of Liberty

- Will assist manager in deciding whether an application to deprive a service user of their liberty is required.
- Document the outcome of the decision.
21.063 Lasting Power of Attorney

- For details of any Written Lasting Power of Attorney and/or advocates.
- Can document any Advance Decisions/refusal of treatment if they become incapacitated (i.e. advance care planning).

21.064 Future Wishes

- Looks at wishes of the service user at end of life (i.e. advance care planning).
- What is important?
- What would they like to happen?
- What would they not like to happen?
- Worries, concerns and special wishes.
- Also looks at what they wish to happen after death.
21.065 Personal Care

- Used to replace a bath book.
- Year on a form.

21.066 Bowel Chart

- To record bowel movements and complications.
- Uses Bristol Stool Chart (poster provided).
21.067 Food Chart

- Enables detailed recording of food intake.
- Sits above MUST Tool in system.

21.068 Weight Chart

- Can document monthly weight on graph to show clearly any dips in weight (and vice versa).
- New version will allow you to monitor as and when required (i.e., daily or weekly).
- Year on form based on monthly review.
21.069 Body Chart

- Can be used to map any bruising or markings that have no explanation but are a concern to staff.
- Could also be used when service user is admitted to hospital and on their return as a safeguard for both service user and staff.

21.070 Epilepsy Chart

- Allows recording of seizures.
- An accurate and comprehensive record.
21.071 Oral Assessment Tool

- Scoring tool to ascertain condition of mouth.
- Suggested actions on reverse to assist care planning.
- Year on form based on monthly review.

21.072 Record of Behaviour

- Allows recording of any behaviour that may be deemed inappropriate and harmful.
- Enables staff to clearly see patterns and triggers etc.
21.075 Manual Handling

- Staff can clearly document which type of handling is appropriate for which movement.
- Any constraints, environmental concerns etc can be recorded.
- Year on form based on monthly review.
21.074 Falls Risk Assessment

- Has questions and necessary actions to prevent the risk of falling.
- Year on a form based on monthly review.
- By identifying risks staff can then state in the care plans how they will be managed and reviewed.
21.097 MUST Poster

- Reference guide for MUST Tool showing BMI chart, Weight Loss table and alternative measurements.

21.073 MUST Tool

- Enables MUST score to be documented.
- Over two and a half years on a form based on monthly review.
- Accompanied by poster with BMI, weight loss table and alternative measurements for quick reference.

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**Table 1: Body Mass Index (BMI) Chart**

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**Table 2: Weight Loss Chart**

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</tr>
<tr>
<td>≥25.00</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 3: Ulna Length Chart**

<table>
<thead>
<tr>
<th>Ulna Length (cm)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20.5</td>
<td>0</td>
</tr>
<tr>
<td>20.5 - 22.0</td>
<td>1</td>
</tr>
<tr>
<td>22.0 - 23.5</td>
<td>2</td>
</tr>
<tr>
<td>23.5 - 25.0</td>
<td>3</td>
</tr>
<tr>
<td>≥25.0</td>
<td>4</td>
</tr>
</tbody>
</table>

**Table 4: Step 5: Management Guidelines**

- Calculate the patient's total score.
- Interpret the score based on the chart below.
- Implement appropriate care plans based on the score.

**Table 5: Step 6: Management Guidelines**

- Monitor the patient's weight and BMI weekly.
- Adjust the care plan as necessary.

**Table 6: MUST Tool Counter**

- Use if you cannot measure service user's actual weight or height.
### 21.077 Infection Risk Assessment
- Evidences that systems are in place to monitor and manage infection control.

### 21.076 Pressure Ulcer Assessment
- Waterlow Score.
- Body map.
- Year on a form based on monthly review.
- Waterlow Manual accompanies form.
21.078
Bedrail Assessment

- Asks risk balance questions.
- Staff get a recommendation via the Risk Matrix Tool.
- Can document your rationale for using (or not) bedrails.
- Consent signature column.
### 21.079 General Risk Assessment

- One form per risk.
- Trigger questions regarding level of risk and actions to be taken.
- In the style of the care plans with tabs.
- Can use evaluation form to evaluate plan without having to re-write.

### 21.080 General Risk Evaluation

- To be used to document the evaluation of the risk assessment.
### 21.081 Pain Chart
- Numeric Pain Scale (for those who can verbalise pain).
- Doloplus2 (for those with a cognitive impairment, i.e., dementia, who cannot verbalise their pain).
- Can assess acute and chronic pain.
- Body Map.

### 21.082 Wound Chart
- One chart per wound for more detailed documentation.
- Accompanies care plan if one is required.
21.083 Depression Scale

- Questions to ascertain whether service user has depression.
- Soon to be one for those with cognitive impairment such as dementia.

21.084 Medication Record

- Document all medication on arrival including short term meds such as antibiotics and any changes to medications.
21.089 Dependency Profile

- Scoring tool to ascertain dependency levels.
- Can be plotted on graph to show patterns of dependency levels.
- Can be used as evidence if applying for continuing healthcare funding (has the same domains).
- Designed to be a monthly assessment and in line with Outcome 21: Records, it can be evidenced on that assessments are updated, monitored and reviewed to ensure records are kept and maintained for each service user.

21.265 Review Timeline

- A snapshot of reviews and those involved over the year.

21.267 Dependency Profile Review

- Sits behind the Dependency Profile enabling staff to record the outcomes of a monthly review.
21.085 Observations and Monitoring
- To record temp, pulse, resps, blood pressure, fluid intake, output and input.
- Can record any relevant comments.

21.086 Diabetic Chart
- Document time, blood sugar and insulin given.

21.088 Fluid Balance
- Document intake and output over 24 hours.
- Two weeks on one form.

21.087 Repositioning Chart
- Document repositioning of service user.
- Two weeks on one form.
21.090 Deterioration Scale

- Recommended by Dr Jo Hockley in line with Gold Standards Framework.
- Can be used to record periodic review of deterioration and required action.

21.260 Catheter Change

- To be used to detail information regarding a new catheter.

21.261 Catheter Care

- To be used for recording all catheter maintenance.
21.091 Keyworker

- Enables keyworkers to document their notes.

21.092 Communication Sheet

- Can be used for general communication purposes.
- Can be used to replace the Communication book.

21.093 Multidisciplinary Notes

- Enables the multidisciplinary team to document their notes.
21.094 Doctors Notes
- Enables Doctors to document the outcome of their visit.

21.095 Family Communication
- Enables family to document any concerns they may have and any communication they wish to get across to staff.
- Recommended by Dr Jo Hockley.

21.096 District Nurse Notes
- Allows District Nurses to document the outcome of their visit.

21.142 Staff Sign in Sheet
- A document that allows staff to sign in to say they have read the contents of the service user’s care plan including risk assessments and tasks required.
- Also useful for documenting staff member’s initials for identification elsewhere in the system.
20.025 Daily Report

- Sits at the back so can be changed very easily.
- A form on which day to day occurrences should be recorded.
- A4 in size.

20.019 Nursing Report

- For use by nursing staff.
- Sits at the back so can be changed very easily.
- A form on which day to day occurrences should be recorded.
- A3 in size.

20.768 Daily Report

- Sits at the back so can be changed very easily.
- A form on which day to day occurrences should be recorded.
- A3 in size.
21.278 Audit Tool

- Audits of care plans are to be done to ensure all staff are recording effectively and that care plans are meeting the requirements of the Care Quality Commission.
- One audit tool should be used per service user care plan. It is best to pick a selection of care plans at random (e.g. 4 in a 40 bedded home = 10%).
- Each audit identifies any documents missing from the care plans, any documents in the care plan that don’t need to be and what percentage of each form is being used correctly.
- Has an area to record the final scores and any action that needs to take place such as further training.

21.319 Audit Tool Quick Checklist

- As above but a quick view checklist for use monthly on all service users if required.

21.280 Visitors Book

- A record of all visitors to the home.
- Includes details such as Date, Name, Company/Car Reg, Who is being visited, Reason, Arrival/Departure Time and Signature.
Domiciliary Care Planning Documentation

Many of our standard documents may be used for Domiciliary Care such as Falls Assessments, Bowel Charts, Food Charts etc. However we have also developed the following documents that are specific to Domiciliary Care, ensuring you can record all the care necessary for the service user in their own home.

21.133 Service User Details
- As well as standard service user details, has such information as house access details and methods of payment
- Designed to sit at the front of the file for quick access

21.134 Support Plan
- A comprehensive assessment of all care required
- Space for reviews
- Views of the service user including their thoughts, wishes and feelings
- Thorough internal and external risk assessment

21.135 Care Plan AM
- Care Plans for AM visit to detail what tasks are to be done on that particular visit
21.136 Care Plan Lunch Visit

- Care Plans for Lunch visit to detail what tasks are to be done on that particular visit.

21.137 Care Plan PM Visit

- Care Plans for PM visit to detail what tasks are to be done on that particular visit.

21.138 Care Plan Night Visit

- Care Plans for Night visit to detail what tasks are to be done on that particular visit.

21.139 and 21.140 Manual Handling and Personal Plan

- An in-depth look at physical, psychological and environmental hazards.
- A section on equipment and dates of inspection.
- What the service user can do for themselves to promote independence.
- The Personal Plan sits behind the Manual Handling form.
- Scoring tool for level of risk.
- Personal Handling Plan for each activity.
21.141 Medication Record
- Risk assessment for self-medication.
- Looks at mental, physical and sensory ability.
- Medication Profile.

21.143 Financial Transactions
- A document to record any financial transactions.
- Amounts given to carer, spent, change returned and receipt given.
- Safeguarding for both carer and service user.

21.144 Daily Log
- All carers to write on Daily Log after visit
- Time In and Time Out
- Full name and signature required
<table>
<thead>
<tr>
<th>Activity</th>
<th>Environment</th>
<th>Equipment to focus</th>
<th>Technique to focus</th>
<th>Potential complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>Indoor</td>
<td>Walker</td>
<td>Stabilizing</td>
<td>Falling</td>
</tr>
<tr>
<td>Standing</td>
<td>Indoor</td>
<td>Cane</td>
<td>Balance</td>
<td>Injury</td>
</tr>
<tr>
<td>Toilet Use</td>
<td>Indoor</td>
<td>Commode</td>
<td>Safety</td>
<td>Infection</td>
</tr>
<tr>
<td>Bathing</td>
<td>Indoor</td>
<td>Shower</td>
<td>Comfort</td>
<td>Skin damage</td>
</tr>
<tr>
<td>Dressing</td>
<td>Indoor</td>
<td>Mirror</td>
<td>Visibility</td>
<td>Discomfort</td>
</tr>
</tbody>
</table>

**Conclusion**

- Any advice or interventions should be documented in the care plan.

**Suggested actions for YES responses**

- Review 3 Staff signature: Date:__________
- Review 2 Staff signature: Date:__________
- Initial review Staff signature: Date:__________

- Have the risks been reduced to the lowest reasonable level? Y / N

- Moving wheelchair
- Turning in bed
- Standing

**Falls Risk Assessment**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Level of risk</th>
<th>Date Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>One carer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin condition: ...........................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: .........................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing balance: .....................................................</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General Risk Assessment**

- Moving wheelchair
- Turning in bed
- Standing

**Mandatory Assessment**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Daily Routines**

- Likes/Dislikes

**Social and emotional needs**

- Practical Skills:

**Assessment of F觉得**

- Nutritional status
- Skin integrity
- Elimination

**Clinical Assessment**

- Blood pressure
- Temperature
- Oxygen saturation

**End of Life**

- Terminal care
- Comfort measures
- Spiritual care

**Risk Assessment**

- Physical risks
- Psychological risks
- Social risks

**Interventions**

- Rehabilitation
- Medical management
- Social support

**Support Services**

- Referrals
- Community support
-其他

**Patient education**

- Medication adherence
- Disease management

**Documentation**

- Progress notes
- Care plan

**Contact Information**

Email: info@standexsystems.co.uk Phone: 01604 646 633

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**RESpite Booklet**

- The Standex System in condensed format for those who are having short term respite.
A Care Plan Continuation sheet ‘add on’ is available to order: 21 269

Nurse/Carer signature:  
Service user/Advocate signature:  
I have been involved with this care plan and all my questions satisfactorily answered.

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**Doloplus-2 Scale (Behavioural pain assessment in the elderly for those with a cognitive impairment e.g. dementia)**

An appropriate analgesic should be administered dependent on what the person is already/not already taking.

Score:  
A ‘Doloplus -2’ score of 5 or more means the service user is likely to be experiencing pain.

---

**3. SOMATIC REACTIONS**

- **Communication unchanged**
- **Sleep pattern normal sleep**
- **Expression usual expression**
- **Protection of sore areas no protective action taken**
- **Pain sites adopted at rest**
- **Protective body posture**

---

**Social Life**

- **participates normally in every activity (meals, entertainment, therapy workshop)**
- **Problems of behaviour**
  - **Washing &/or dressing**
  - **Mobility usual abilities & activities remain unaffected**
  - **Expression showing pain when approached**
  - **Expression showing pain even without being approached**
  - **Protective actions taken at rest, even when not approached**
  - **Protective body posture sought**
  - **occasional involuntary complaints**
  - **Complaints expressed upon inquiry only**

---

**Numeric Rating Scale (for those able to verbalise their pain)**

<table>
<thead>
<tr>
<th>Pain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Chart</td>
<td>Worst pain</td>
<td>Severe</td>
<td>Very severe</td>
<td>Pain</td>
<td>Other/Describe</td>
<td>Oedematous/Dry/Scaly</td>
<td>Discoloured skin (red/purple)</td>
<td>Blue/green</td>
<td>Granulating (red)</td>
<td>Epithelialising (pink)</td>
<td>Infected/Colonised (green)</td>
</tr>
</tbody>
</table>

---

**Skin:**

- **Surrounding Colour:**
  - **Variation in colour:**
    - **Skin:**
    - **Surrounding Colour:**
      - **Skin Temperature:**
      - **Wound Bed/Dimensions:**
      - **Factors that may delay healing:**

---

**ASSOCIATIONS/RECORDS**

- **Type of wound:**
  - **Causes:**
  - **Undermining:**
    - **Depth:**
      - **Length:**

---

**WOUND ASSESSMENT CHART**

- **Date:**
- **Time:**
- **Report:**
- **Signature:**

---

**ASSESSMENTS/RECORDS**

- **Mandatory:**
  - **Day to Day Recording**
  - **Mandatory Assessments/Records**
  - **Mandatory Nursing Information**
  - **Mandatory Information**
  - **Mandatory Alzheimer’s/Dementia**
  - **Mandatory Review**
  - **Mandatory Training**

---

**OTHERS**

- **Optional/Nursing Information**
  - **Domestic Care**
  - **Respite**
  - **Recording & Communication**
  - **Dementia & Mental Capacity Information**
  - **Assessment & Records**
  - **Filing & Storage**
  - **Accessories**
  - **Other**

---

**DOCUMENTATION**

- **Information on the service user file**
  - **Maps/Tracings in maps/tracings in service user file**
  - **Attach any photographs or other data**
  - **Indicate location on the body map**

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**WEB:**

- www.standexsystems.co.uk
- Fax: 01604 644 646
- Web: www.standexsystems.co.uk
Contact your local business manager for a no obligation care planning consultation for your care home.

For any guidance or advice on all aspects of care planning, please contact our Nurse Advisor, Lucy Caldwell RGN on 01604 646 633.

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