Best Possible Health Plan

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Personal Definition of Best Possible Health

Staff Note: Please refer to the Best Possible Health information leaflet to assist a person to develop their personal definition

What does being healthy mean to you?

Describe:

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Who would you like included in the development of this Best Possible Health Plan with you (e.g. Family member / Friend / Advocate)?

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Do you require support to access to Independent Advocacy Services?

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Do you require support / consultation regarding decision making about your health?

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Signed: --- **Date: ---------**

Signed: --- **Date: ---------**

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A. Personal Information

Name/Preferred Name:	Address:
Date of Birth:	**Phone:** **Mobile No:** **Email:**
G.P: **Name:** **Address:**	**P.P.S. No:**
Religion:	**Medical Card No:**
Blood Type:	**Medical Insurance No:**
Key Worker/Advocate: **Name:** **Address:** **Phone:** **Mobile No:** **Email:**	**Next of Kin/First Contact:** **Name:** **Address:** **Phone:** **Mobile No:** **Email:**
Primary Disability: **Describe:**	**Secondary Disability:** **Describe:**
Past Medical History:	

Allergies	
Cause of Allergy (e.g. medication / food)	**Reaction**
1.	
2.	
3.	
4.	

B. General Information

People who know about my health and help keep me healthy

Title	Name/Address	Contact Details
Family member:		
Friend:		
G.P. ***(Staff note: check with the person that this is the G.P. of their choice)***		
Public Health Nurse:		
Dentist:		
Physiotherapist:		
Speech and language therapist:		
Occupational therapist:		
Dietician:		
Chiropodist:		
Psychiatrist:		
Hygienist:		
Optician:		
Psychologist:		
Advocate:		
Other:		
Other:		

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C. Communication

How I communicate with others? Please tick the box(es) that apply		
	Tick here	Additional Comments
I can speak clearly		
I do not use speech to communicate		
I have difficulty in understanding long sentences or words		
Using noises and gesture		
Use of body language		
Use of objects		
Use of sign		
Use of an electronic communication aid		
Use of a communication diary		
I have guidelines that will help us to communicate better		
Other systems used (please specify)		
What is your first language?		
Do you access supports around communication (e.g NCBI, Speech Therapy)? If no, do you feel you need to?		
Reading and Writing		
I can read on my own		
I am able to read information, which is brief and jargon free, with some support		
I use supports to read (e.g. NOVA)		
I am unable to read		
I am able to write to make my needs known		
I am unable to write		

Priority Areas for Action relating to Communication

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D. Personal Care

Staff Note: Please ensure the person has an up to date Moving and Handling Plan. This will outline level of assistance required for all transfers. *If a Moving and Handling plan is not in place please identify as a Priority Area for Action for Personal Care*
Dressing
Do you require assistance with upper body dressing? **If yes, describe preferences:**
Do you require assistance with lower body dressing? **If yes, describe preferences:**
Staff Note: Please ensure that the individuals clothing is appropriate to the weather and suits the individuals personal preferences
Bathing
What are your bathing preferences (e.g. bath, shower)? **How often do you like to have a shower/bath?** **What kind of body/hair products do you like?**
Personal Grooming
Do you have any preferences regarding your hair care (e.g. styling)?
Do you have any preferences regarding facial shave (e.g. wet shave/electric razor)?
Do you require assistance with application of make-up?
Do you require assistance with care of finger nails? **Do you have any preferences regarding filing/polish?**

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Oral Health
Do you need any support to keep your teeth and gums healthy?
Do you have any problems with your teeth and gums?
Do you use false teeth/dentures? **Do you require assistance with care of false teeth/dentures?**
How often do you attend for a dental check?
Staff Note: Please ensure an appointment for dental check is noted in the Priority Areas for Action for Personal Care if required (annual appointment is appropriate)
Foot Care
Do you have any problems with your feet or toe nails? Please describe **Do you have any special requirements regarding care of your feet/toenails?** **Do you currently attend a Chiropodist?**
Do you have any specially fitting footwear/orthotics (i.e. shoe inserts)? **Do you attend a Podiatrist?**
Staff Note: If any problems which are not being treated are highlighted please identify in Priority Areas for Action for Personal Care. This may require appointments with Chiropodist/Podiatrist.

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Vision
Do you have any difficulties with your vision? **If yes, describe:**
Are you registered blind or are you partially sighted? **Do you access services from the National Council for the Blind Ireland (NCBI)?** **If yes describe:**
Do you wear glasses/contact lenses? **Do you require assistance with care of glasses/contact lenses?** **Do you use aids/appliances to assist with your vision?**
When was the last time you visited the Optician?
Staff Note: Please ensure appointment with the Optician or NCBI representative is noted in the Priority Areas for Action for Personal Care if required
Hearing
Do you have any difficulties with your hearing? **If yes, describe in relation to right ear and left ear:**
Do you use a hearing aid? **Do you require assistance with application and care of your hearing aid?**
How often do you attend the Audiologist?
Staff Note: Please ensure appointment with the Audiologist is noted in the Priority Areas for Actions for Personal Care if required

Skin Care
Do you have any skin conditions? **If yes, describe these and any treatments:**
Staff Note: Please note the individuals Waterlow score
Do you have any pressure areas / wounds? **If yes, outline the locations:** **How are these pressure areas managed (dressings, positioning)?** **Do you use any pressure relieving aids (mattress, cushion)?** **Do you have a specific turning schedule to manage pressure relief?** **If yes, when was this last reviewed:** **Where is the turning schedule displayed/stored?** **Do you have a history of pressure areas / wounds?** **If yes, outline the locations**
Do you use sunscreen / protective clothing when outdoors?
Staff Note: Please document any medication which may affect the individuals tolerance of sunshine

Menstrual Care
Do you have any difficulties regarding your menstrual care **Do you require any assistance with your menstrual care** **Do you have a preference regarding feminine hygiene products (e.g. sanitary towels, tampons etc)** **Do you experience any discomfort during your menstrual cycle (e.g. abdominal pain, P.M.T)**

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Priority Areas for Action relating to Personal Care

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E. Bowel and Bladder Care

Bladder Care
How do you currently manage your bladder care (e.g. use of toilet / catheter / bedpan / commode / urinal)? **What assistance do you require with your bladder care?**
Are you continent? **If no, do you use any continence care products (e.g. continence pads)?** **Do you have a continence assessment care plan?** **If yes, when was this last reviewed?**
Staff Note: Please ensure that the individual has an up to date continence assessment care plan, if required. If a new continence assessment care plan or an updated plan is required, please ensure this is noted in the Priority Areas for Action for Bowel and Bladder care.
Catheter Care
Do you have a catheter? **If yes, describe the type of catheter (e.g. in-dwelling, supra pubic)** **Do you have any difficulties with your catheter?** **If yes, please describe:**
Do you experience frequent urinary tract infections (U.T.I's)? **If yes, how are these managed?**

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Bowel Care
How do you currently manage your bowel care? **What assistance do you require with your bowel care?**
Do you use aperients (oral laxatives)? **Do you use suppositories / enemas?** **Do you require assistance with bowel evacuation?** **Do you experience any specific problems with your bowels (e.g. diarrhoea, constipation)?**
Do you have a stoma bag? **If yes, what assistance do you require to manage this?** **What assistance do you require with the management of the stoma site?**

Priority Areas for Action relating to Bowel and Bladder Care

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F. Diet and Nutrition

What do you prefer to eat / drink for: **Breakfast:** **Lunch:** **Dinner:** **Are there any foods / drinks that you dislike?** **Do you have any special dietary needs (e.g. gluten free, sugar free, cholesterol management)?**
Staff Note: Please ensure dietary preferences are communicated to the appropriate kitchen staff
Do you require any assistance with eating and drinking? **If yes, please describe:** **Do you use any aids / appliances when eating and drinking?** **Do you have an specific positioning requirements when eating and drinking?**
Is there an amount of fluid you are required to drink when eating?
Do you have any swallowing difficulties? **Do you require your food prepared to a specific consistency (e.g. soft diet, puree etc.)?** **Do you require thickeners in your fluids?** **Have you been assessed by a Speech and Language therapist?**
Staff Note: ***Please ensure appointment for Speech and Language therapy assessment is noted in the Priority Areas for Action for Diet and Nutrition if required***

Community Living (if indicated)
Do you require assistance with cooking of meals? **Do you require assistance shopping for food / drinks?** **Do you require assistance developing a weekly meal plan?** **How many meals do you like a day?** **What times do you prefer to eat your meals?**

Priority Areas for Action relating to Diet and Nutrition

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G. Respiratory Care

Do you have any breathing / respiratory difficulties? If yes, how are these managed? Have you been seen by a Physiotherapist in relation to your chest? Do you smoke? Do you require any assistance with Chest Physiotherapy exercises for respiratory care?
Staff Note: Please ensure appointment for Physiotherapy assessment is noted in the Priority Areas for Action for Respiratory Care if required
Do you use any devices to assist with respiratory function (e.g. inhaler, oxygen)? If yes, do you require assistance with the use of these? Do you have any positioning requirements to maintain healthy respiratory function during daytime / night-time?
Do you suffer from recurrent chest infections? If yes, how are these managed?

Priority Areas for Action relating to Respiratory Care

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H. Medication Management

Please list your current medications		
Name of Medication	**Reason for taking this**	**How much do you take**
Staff Note: Please attach a copy of the individuals current Medication Administration Record		
Management of Medication		
Do you currently manage your own medication (i.e. take full responsibility for administration, dosage etc. Cheshire Ireland may provide some physical assistance)? **Do you understand that if you manage your own medication, Cheshire Ireland take no responsibility in relation to administration, documentation etc?** **Does Cheshire Ireland take responsibility for the management of your medication?** **Would you like to manage your own medication independently in the future?**		
Staff Note: If there is a concern regarding the cognitive capacity of the person, please refer to Care Team Leader / Service Manager. If the individual has stated that they would like to manage their own medication in the future, please refer to Care Team Leader / Service Manager		
Staff Note: If the person takes full responsibility for their medication, please clearly outline, discuss and document all the health implications regarding responsibility for taking medication (e.g. importance of taking certain medications daily and the health and safety consequences of same).		
Is your medication blister packed?		

Who checks the medication in your blister pack when it arrives in your home (only relevant if Cheshire Ireland are responsible for the management of the medication)?   **Where is your medication administration record stored (only relevant if Cheshire Ireland are responsible for the management of the medication)?**   **When was your last medication review with your G.P?**
Staff Note: Each person is required to have a full medication review with their G.P on an annual basis. Please ensure appointment with G.P. (including full blood work examinations) is noted in the Priority Areas for Action for Medication Management if required

Priority Areas for Action relating to Medication Management

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I. Mobility and Positioning

Mobilisation
Do you mobilise independently? **Do you require any assistance with your mobility?** **If yes, please describe** **Do you use any aids / appliances to assist your mobility (e.g. wheelchair, walking aid)?**
Wheelchairs
What type of wheelchair do you use (e.g. manual, electric)? **Do you have any difficulties with your wheelchair?** **Do you use any seating devices / adaptive equipment (e.g. cushion, headrest)?** **Are you having any difficulties with these seating devices / adaptive equipment?** **Is your wheelchair suitable for your living environment (e.g. accessibility, indoor/outdoor use)?** **Do you need assistance with using your wheelchair?** **How often does your wheelchair need to be charged?** **Have you had a seating assessment with an Occupational Therapist?** **When was your wheelchair last serviced?**
Staff Note: If the person has never had a seating assessment or if the person is identifying difficulties with the wheelchair / adaptive equipment, please ensure appointment with O.T. is noted in the Priority Areas for Action for Mobility and Positioning if required ***Each wheelchair must undergo a service on an annual basis. Please***

ensure appointment with appropriate professional is noted in the Priority Areas for Action for Mobility and Positioning if required.
Positioning
Do you have any specific positioning or adaptive equipment requirements: **During the day?** **At night?** **Do you use splints?** **If yes, please describe type of splints and application time / duration:** **Do you suffer any skin irritation as a result of the splints?**
Joint Mobility
Do you have any specific exercises to maintain joint range of motion? **If yes, do you require any assistance with these?** **Do you experience muscle spasms?** **If yes, please describe frequency, location, duration:** **Please describe spasm management techniques (e.g. positioning, stretching, medication)**

Priority Areas for Action relating to Mobility and Positioning

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J. Safe Living Environment

Are there specific aspects of your accommodation that are unsuitable to your needs (e.g. accessibility, lighting, heating)? **Do you feel safe living here?** **If no, what would help you to feel safer (e.g. alarms, access to bell, security devices)?** **Do you have a Personal Egress Emergency Plan (P.E.E.P)?** **Do you know what to do in the event of a fire?** **Are you aware of the location of emergency exits, safe zones, alarms etc?**
Staff Note: Please ensure the person has an up to date Personal Egress Emergency Plan (P.E.E.P). If a Personal Egress Emergency Plan (P.E.E.P) is not in place please identify as a Priority Area for Action for Safe Living Environment.

Priority Areas for Action relating to Safe Living Environment

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K. Lifestyle and Well-being

Staff Note: This is the beginning of a conversation with people around their emotional well-being and will be explored further as part of the development of an individual lifestyle plan
Physical Well-being
What do you do for leisure time / relaxation? **What recreational activities do you enjoy the most?** **Do you engage in any exercise / physical activities to promote your physical well-being (e.g. swimming)?**
Do you have any difficulties with sleep (e.g. insomnia, nightmares)? **What promotes sleep?**
Emotional Well-being
Do you meet with family / friends / community groups as often as you would like? **What are your aspirations / goals?** **Are there any situations which you find stressful?** **How do you cope with these?** **Are you able to express your spirituality (e.g. practice your religion, attend retreats, meditation)?** **Do you require support to manage your emotional well-being (e.g. counselling)?** **Do you require any support around alcohol or other drug consumption (e.g. counsellor)?**
Staff Note: Please ensure appointment with Counsellor / Mental Health Services is noted in the Priority Areas for Action for Emotional Well-being

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if required. If you are aware of any specific behaviours which may be challenging or complex, please refer to Care Team Leader / Service Manager as a risk assessment may need to be carried out.
Do you require support to express intimacy? **Do you require any support around your sexual health / well-being (e.g. information, education etc)?**
Do you require access to independent advocacy?
Staff Note: Please refer to "Supporting Advocacy in Cheshire Services" Handbook for staff

<u>Priority Areas for Action relating to Lifestyle and Well-being</u>

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L. Management of Unexpected Medical Events

Should an unexpected medical event occur, do you have any specific requests or requirements? If you have to go to hospital, are there any specific items you wish to bring with you?
Are there any particular customs you wish to have followed / carried out in the event of an unexpected medical emergency? Do you have any specific wishes regarding end of life care? Do you have any specific wishes regarding resuscitation?
Staff Note: If the individual has not documented their wishes regarding resuscitation, please note this as a Priority Area for Action for the Management of Unexpected Medical Events and referred to Service Manager / Care Team Leader. An Individuals Next of Kin / Advocate and G.P. may be involved in these discussions.

Priority Areas for Action relating to the Management of Unexpected Medical Events

M. Additional Considerations

<table>
<tr><td colspan="3">Staff Note: If an individual has a condition which may pose a risk to their health (e.g. Epilepsy, Asthma, Diabetes, Vertigo, Recurrent Infections, Autonomic Dysreflexia), please outline the presentation and management of this condition.
If an individual has any infection (e.g. M.R.S.A), please identify the nature of the infection and if it is localised in a particular site (e.g. a particular wound)</td></tr>
<tr><th>Condition</th><th>How does this affect you?</th><th>How is this managed?</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Staff Note: If you are unfamiliar with any of the conditions given as examples above (or their symptoms) please refer to Care Team Leader / Service Manager</td></tr>
</table>

Priority Areas for Action relating to Additional Considerations

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N. Health Checks

Female		
Test / Check	**Recommended (Time & Age Group)**	**Date of test / check**
Cervical Smear	**Between 25 – 60 yrs (Every 3-5 yrs)**	
Breast Examination	**Over 50yrs (every 2yrs until 65)**	
Mammogram	**Over 50yrs (every 2yrs until 65)**	
Bone Density Scan	**As recommended by G.P**	

Male		
Test / Check	**Recommended (Time & Age Group)**	**Date of test / check**
Testicular Examination	**Contact local cancer screening services**	
Prostate Examination	**Over 50 yrs (no recommended frequency)**	
Bone Density Scan	**As recommended by G.P**	

Staff Note: Please ensure the individual has had the appropriate tests within the recommended timeframes. If they have not, please ensure appointment with G.P / appropriate medical clinic is noted in the Priority Areas for Action for Health Checks

Priority Areas for Action relating to Health Checks

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Appendices

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Appendix 1: Best Possible Health Priority Areas for Action Summary

Communication: What is to be done? Be Specific.	By who?	By when?	Date
Personal Care: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Bowel & Bladder Care: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Diet & Nutrition: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Respiratory Care: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Medication Management: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Mobility & Positioning: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Respiratory Care: What is to be done? Be Specific..	**By who?**	**By when?**	**Date**

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Safe Living Environment: What is to be done? Be Specific.	By who?	By when?	Date
Emotional Well Being: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Management unexpected medical events: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Additional Considerations: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**
Health Checks: What is to be done? Be Specific.	**By who?**	**By when?**	**Date**

It is the responsibility of the **Service Manager** and the **staff member trained in Best Possible Health who conducted the process with the person,** to ensure that all staff are aware of their role in supporting the person around their health as outlined in this individual plan. This plan should be reviewed on an annual basis with the person.

Signed: ______________________________ **Date**
Person

Signed: ______________________________ **Date**
Staff Member

______________________________ **Date**
Signed **Service Manager**

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Appendix 2: Best Possible Health Daily Care Plan

Name ___________________________________

Address ___________________________________

- This document provides a summary of the information gathered through the Best Possible Health process
- This is the person's active care plan outlining what the person's support needs are in relation to their health and well being for staff to follow on a daily basis
- This was developed with the following individuals (family, staff members names):

Name:__________________________ Name:______________________________

Name:__________________________ Name:______________________________

Name:__________________________ Name:______________________________

Name:__________________________ Name:______________________________

Date :_________________________________

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Communication	Daily Care Plan	Date & Sig

Personal Care	Daily Care Plan	Date & Sig
Dressing		
Bathing		
Grooming		
Oral Health		

Personal Care	Daily Care Plan	Date & Sig
Foot Care		
Vision		
Hearing		
Skin Care		
Menstrual Care		

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Bowel and Bladder Care	Daily Care Plan	Date & Sig
Bladder Care		
Catheter Care		
Bowel Care		

Diet & Nutrition	Daily Care Plan	Date & Sig

Respiratory Care	Daily Care Plan	Date & Sig

Medication Management	Daily Care Plan	Date & Sig

Mobility and Positioning	Daily Care Plan	Date & Sig
Mobilisation		
Wheelchairs		
Positioning		

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Joint Mobility		

Safe Living Environment	**Daily Care Plan**	**Date & Sig**

Lifestyle and Well-being	**Daily Care Plan**	**Date & Sig**
Physical Well-being		
Emotional Well-being		

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<u>Daily Communication Sheet</u>

This sheet is to be used to record any comments or observations relating to the day to day healthcare of the individual

Date	Comments	Signature

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Appendix 3. Unexpected Medical Event Transfer Form (To be completed if service user is ill and may have to leave their home)

Section 1; Basic information sheet

Name/Preferred Name:	Address:
Date of Birth:	Phone: Mobile No: Email:
G.P: Name: Address:	P.P.S. No.
Religion	Medical Card No.:
Blood Type:	Medical Insurance No:
Key Worker/Advocate: Name: Address: Phone: Mobile No.: Email:	Next of Kin/First Contact: Name: Address: Phone: Mobile No: Email:
Primary Disability: Describe:	Secondary Disability: Describe:
Allergies	
Cause of Allergy (e.g. medication / food)	**Reaction**
1.	
2.	
3.	
Infections	

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Section 2; Transfer Information (to be completed at time of transfer)

Please describe the main reason for the transfer?
Has the First Contact / Next of Kin been notified?
Describe any special requirements the service user has in relation to: **Communication:** **Eating / Drinking / Dietary Requirements:** **Personal Grooming / Dressing:** **Bowel / Bladder care:** **Mobility / Positioning:** **Skincare:**
Outline a list of current medications and dosage:
Please describe any particular customs the individual wishes to have followed / carried out in the event of an unexpected medical emergency:
Please outline any other relevant information:
Completed by:___________________________ Date:______________________

Appendix 4. Appointment Log (this should be filled out when the person visits the following clinicians)

Staff Note: Examples of Clinical Appointments to be documented include: G.P; Public Health Nurse; Dentist; Physiotherapist; Local Caredoc; Optician; Speech and Language therapist; Occupational therapist; Dietician; Continence advisor/Urologist; Chiropodist; Podiatrist; Audiologist; Psychiatrist; Psychologist; Community Psychiatric Nurse; Hygienist (list is not exhaustive).

Clinician	Appointment Date	Appointment Notes	Next Appointment