EFORMS, Test (Mrs)
BORN 27-Feb-1988 (37y) GENDER Female
CHI 3333333333

Future Care Plan

Last updated by Maureen BOWERS (Maureen Bowers) on 16-Jun-2025 14:39 (v. 9)

Please be aware that an eKIS may exist for this patient

0. Trigger for Future Care Plan, Frailty Score and Special Notes

Article 6(1)(e) of the UKGDPR in conjunction with the Intra NHS Scotland Sharing Accord allow the information contained within this document to be shared with Primary Care and other NHS Boards including NHS 24 and Scottish Ambulance, without the need for explicit consent. We are sharing this information for routine patient care as part of our Board's duty to provide healthcare to our patients. It is best practice for staff to make sure the individual and/or their legal proxy is aware this information will be shared when conducting Future Care Plan conversations. If the patient would like further information about how the Board uses their data it can be found in our Privacy Notice here

Review

Date of review	08-Jan-2024
Reviewed by	Marina Bowes
Job Family	Nursing/Midwifery
Directorate/Sector	Renfrewshire HSCP
Trigger for Future Care Plan / Update	LTC Diagnosis /Progression
Contact Telephone No	0123 111 0000
Date of Next Review	30-Jun-2025

Review

Date of review	07-Feb-2025
Reviewed by	Derek Brown
Job Family	Social Work
Directorate/Sector	Renfrewshire HSCP
Trigger for Future Care Plan / Update	Review / Update
Contact Telephone No	0123 111 0000
Date of Next Review	—

Review

Date of review	14-May-2025
Reviewed by	Cara Alexander
Job Family	Nursing/Midwifery
Directorate/Sector	Renfrewshire HSCP
Trigger for Future Care Plan / Update	Review / Update
Contact Telephone No	0101 123 9876
Date of Next Review	—

Following initial conversation would individual (or their legal guardian) like to share information via Future Care Plan?	Yes

Information Guidance Notes for recording whether some would like to share information via Future Care Plan

Clinical Frailty Score (Rockwood)

Information Please click here for Clinical Frailty Scale definitions

Consider carrying out Rockwood frailty assessment and select score	5 Mildly frail

Special Notes / What is important to the individual?	Nursing Team Notes 08.01.25: Dave has been diagnosed with Heart Disease and COPD. Leg ulcer left leg, reduced mobility and swelling on both his lower limbs. Regular low moods since death of wife. Recent discharge from hospital - COPD exacerbation.

Dave lives alone at Goodview Sheltered Housing Complex - front door entry system, upper floor (lift). Max the cat keeps him company. Warden provides daily check. He feels safe here and when well, he will join in with day room activities, he especially likes a good old sing-a-long. He has stated that he doesn't feel up to company at the moment and often gets depressed.

He has good support from nephew, Craig (sole contact/NOK) - he visits once a week, mostly Sundays (to check Dave's okay and bring shopping). Craig also supports Dave with any appointments, this helps keep him informed. Craig has work and family commitments and sometimes struggles with this. Craig is aware of the plan and happy to support this - he has been concerned about his uncle's decline and need for a conversation about his care and future living arrangements.

Other services: Receiving twice weekly home care visits for assistance with personal care and some daily living activities.
No immediate communication needs identified (eyesight is failing and Dave feeling more vulnerable).
Dave would also like to reconnect with his church - will arrange for minister to visit.
Craig agreed to look after Max if things change for Dave.

Social Work Notes 07/02/25:
Re-referral made to Home Care to increase service daily over 5 days. Possible referral for day care place/warden will encourage Dave to engage in day room activities. Discussed long term care - options to consider.
Dave is aware that his health has declined and that he may require more support in the future. Referral to Carer Services for support - Craig.

District Nursing Team Notes 14-05-25:
Mr Langton's nephew Craig, contacted the health centre to confirm the POA has now been registered, certificate verified. Home Care Service increased on daily bases. Day Care place offered, attending 1 day per week for now (Wednesdays).

Emergency Plan in place for Craig - copies held with Craig plus uncle's home (under TV in drawer - other important documents kept here).

1. Next Of Kin / Carer

All staff have a duty to identify carers as soon as possible and inform them of their right to support. Carers can be referred to local Carer Support Services. Contact details of local carers services can be found at www.nhsggc.scot/carers (carers can also self-refer if they wish).

Next of Kin

Title	Mr
Forename(s)	Craig
Surname	Quinn
Gender	Male
Address (inc postcode)	8 Horizon Avenue, Renfrew, X00 0OO
Telephone Number(s)	07912345678
Relationship	Nephew
Keyholder	Yes

Is Next of Kin also the Carer? Yes

Carer

Title	Mr
Forename(s)	Craig
Surname	Quinn
Gender	Male
Address (inc postcode)	8 Horizon Avenue, Renfrew, X00 0OO
Telephone Number(s)	07912345678
Relationship	Nephew
Keyholder	Yes

Other Agencies Involved

Other Agencies Involved	Contact Numbers
District Nursing Team	0123 111 0000
Rehab Team	0123 222 1111
Home Care Service Co-ordinator	0123 222 3333
Sheltered Housing Warden	079111111111
OPMH	0123 222 0000
Carers	0123 102 2222

2. Current Health Problems / Significant Diagnoses

Information Please click here for Guidance Notes for Current Health Problems / Significant Diagnoses

Current Health

Problems / Significant Diagnoses	Nursing Team Notes 08.01.25: Dave has been diagnosed with heart disease (Arterial Fibrillation, COPD). Also has a leg ulcer which requires visits from the District Nursing Team, this has reduced his mobility with swelling on both his lower limbs. COPD causing shortness of breath and this adds to his lack of mobility and poor circulation. Excessive smoker. Has been living with depression since death of wife. Hospital admission December 2024 - exacerbation COPD/increased SOB. Admission required IV antibiotics and nebulisation therapy for 48hours due to O2 levels 86% on admission. Current baseline O2 levels dropping - 92% (decline from previous level 94%). Resting Respiratory rate - 20. Currently on Spriva and Ventolin inhaler with Mucodyne TDS. Treatment Plan: OPMH Team to support Dave's depression and monitor, GP has reviewed meds. Will liaise with warden. District Nursing Service - leg ulcer management twice weekly. Rehab/Physio - support plan for exercise and leg elevation, strength/balance and improve sleeping habits. Provision of equipment as required. Respiratory Nurse supporting COPD management. Discussion with patient: salbutamol nebules - has agreed to this medication change to support breathing. Dietician input to improve diet and intake of fluids. Smoking Cessation - Dave will try the 12 week programme. To return to independent function and living - Home exercise programme: improve mobility - indoors & out Risks Health deterioration due to chronic leg ulcer (increased chance of further infections and build-up of fluid), COPD exacerbation/choking, decline in mental health status causing concern. Possible risk of falls. Avoid need for re-admission to hospital Return to independent mobility and reduce dependence on WF. Return to independent function, ADLs and some personal care Prevent carer breakdown (including carer support) No known allergies.

Essential Medication and Equipment

Oxygen Therapy	No
Anticipatory medication at home	No
Continence / Catheter Equipment at home	No
Syringe Pump	No
Moving and handling equipment at home	No
Mobility equipment at home	Yes
Mobility equipment notes	walking frame, grab rails, pull cord alarm

3. Legal Powers

Does the individual have a Combined Power of Attorney (financial & welfare)? Yes

Is POA in use? No

Name & Address of Combined POA

Name	Address	Part of POA Held
Craig Sullivan	8 Horizon Avenue, Renfrew X00 0OO	Both - Finance & Welfare

Has the Power of Attorney paperwork been verified? Yes

Date of verification 01.08.2025

Name of verifier Marina Bowes, DN

Is an Advanced directive in place (living will)? No

Is an Adult with Incapacity Section 47 held? No

Has a Guardianship been appointed under the Adults with Incapacity (Scotland) Act 2000? No

4. Preferred Place of Care & Resuscitation

My preferred place of care

Nursing Team Notes 08.01.25:
Dave has expressed that he wishes to be cared for at home where possible but is willing to be cared for in a care/nursing home should this be required. He does not wish any burden of care on his family. He/family will discuss options with Social Services.

Information Guidance Notes for preferred place of care

My views about hospital admission / views about treatment and interventions / family agreement

Nursing Team Notes 08.01.25:
Dave has stated that he is not for any further unnecessary treatments that prolong his life and not for hospital admission should his health seriously decline. He wishes to be kept comfortable at his place of home with oral medications.

He is anxious about hospital admission and wishes to avoid this if possible, but will consider interventions for reversible conditions where recovery can be then managed at home.

All conversations took place alongside Nephew - understanding and agreement on all decisions.

Has a Treatment Escalation Plan Yes

(TEP) ever been created for this person?

Date of TEP Creation	Hospital of Admission (if known)	Level of Escalation
20-Dec-2024	QEUH	Ward Based

Information Guidance Notes for views about hospital admission / views about treatment and interventions / family agreement

Has DNACPR been discussed?	Yes	Comments	Patient and family have discussed and are aware of views.
Is a DNACPR Form in place?	No	Comments	—
Refer to GP for further discussion re DNACPR	Yes	Comments	More information required - what this means and process. Will follow up with email referral to GP.
Form Closed	No		

When you click to 'Complete' a copy of the Future Care Plan Summary will be sent electronically to the registered GP practice.

Amendments (8)

v.9 - discharge hospital
16-Jun-25 14:39 by Maureen BOWERS
v.8 - discharge hospital
16-Jun-25 13:23 by Maureen BOWERS
v.7 - discharge hospital
16-Jun-25 10:27 by Maureen BOWERS
v.6 - Hospital Discharge
14-Jun-25 16:36 by Maureen BOWERS
v.5 - discharge to care home
11-Jun-25 17:20 by Maureen BOWERS
v.4 - discharge hospital
06-Jun-25 15:13 by Maureen BOWERS
v.3 - hospital discharge
05-Jun-25 15:23 by Maureen BOWERS
v.2 - discharge from hospital
04-Jun-25 18:00 by Maureen BOWERS