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

Future Care Plan

Last updated by Maureen BOWERS (Maureen Bowers) on 17-Jun-2025 09:18 (v. 10)

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	Allied Health Profession
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	6 Moderately frail

Special Notes / What is important to the individual?	Rehab Team 08.01.25: Mrs Smith (likes to be called Mo) lives at home alone in a ground floor 4 in a block house (r-h-s, key code access) – she is currently housebound post hospital discharge (COPD exacerbation), daily living activities impaired due to breathlessness.

Main carer is her daughter Sarah Smith (lives locally), Sarah deals with daily needs including personal care, household chores and supports Mrs Smith with any appointments. Sarah has been concerned about her mother's long term care as her own situation is changing.
Son, Paul Smith (NOK) keeps in contact mainly by telephone. Mrs Smith has strong family links and she enjoys spending time together when possible.

Mrs Smith has clear understanding of diagnosis and is happy to discuss plans for the future. Since discharge, Mrs Smith has experienced high levels of anxiety when she has been unwell and is on her own, particularly around her breathing. Since her discharge from hospital she has been unsteady on her feet, she is frightened of falling and having no-one around to help her.

Communication Needs - Glasses and magnifier used daily.
No POA in place - have provided information on this, family will look into and update once processed.

Mrs Smith is a practicing Roman Catholic and it is important that she can continue to engage with her faith.
Mrs Smith an 8 year old cat, Kitty. Sarah (daughter) is happy to look after her if necessary.
Health Goal – to improve mobility and return to social activities, including getting back to the lunch club to see her friends and attend her daughter's wedding (Spring 2026).

Social Services 07/02/25:
Home service initiated 03/02/25, 2 x daily / 5 days per week, has pendant alarm via Telecare (03/02/25).
Referral made to local carer service for carer support plan including carer emergency plan.

District Nursing 04-06-25:
Visit to Health Centre by daughter, Sarah: POA has now been registered and verified.
Emergency Plan in place for Sarah. Copies of paperwork - Mrs Smith's home (in living room, under TV in drawer with all important documents). Copies held with Sarah.

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)	Paul
Surname	Smith
Gender	Male
Address (inc postcode)	8 Horizon Avenue, Ayr, Z00 0OO
Telephone Number(s)	07912345678
Relationship	Son
Keyholder	Yes

Is Next of Kin also the Carer?	No

Carer

Title	Ms
Forename(s)	Sarah
Surname	Smith
Gender	Female
Address (inc postcode)	1 Hunter Avenue, Renfrew, X00 2OO (first contact in emergency)
Telephone Number(s)	07812345678
Relationship	Daughter
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
Social Services	0124 111 0000
Continence Team	0123 222 0000
Carers Services	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

Rehab 08.01.25:
COPD with decline over the last 6 months. Increased hospital admissions with exacerbation COPD. Mobility poor, breathing impaired and experiences anxiety. Continence Issues. Housebound.

Baseline O2 levels dropping. 2 hospital admissions in the last 4 months with exacerbation COPD/increased SOB - both admissions required IV antibiotics and nebulisation therapy. Most recent O2 therapy was required for 48hrs due to O2 levels 86% on admission. Baseline O2% (Dec 2024) - 92% (decline from previous levels from Sept 24 which were 94%). Resting Respiratory rate - 20. Currently on Spriva and Ventolin inhaler with Mucodyne TDS.

Treatment Plan:
Discussion with Mrs Smith re: salbutamol nebules and she is keen to start. DN's and Community Respiratory Team will monitor Mrs Smith to manage her breathing and anxiety.
Provision of equipment as required.
Home exercise programme.
To progress from WF - Gait re-education and progress to stick
To return to independent function and living

Referral to Continence Nurse
Awaiting Ophthalmology review - bilateral glaucoma identified by optician 6 weeks ago, (xalatan drops meantime).
Referral to Social Work to access home care service and social support.

Risks
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 (through carer support)

No known allergies/addictions.

Essential Medication and Equipment

Oxygen Therapy	No		
Anticipatory medication at home	No		
Continence / Catheter Equipment at home	Yes	Continence / Catheter Equipment notes	supply of pads
Syringe Pump	No		
Moving and handling equipment at home	No		
Mobility equipment at home	Yes	Mobility equipment notes	walking frame, grab rails, pendant 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
Paul Smith Sarah Smith	8 Horizon Avenue, Ayr, Z00 0OO 1 Hunter Avenue, Renfrew, X00 2OO	Both - Finance & Welfare

Has the Power of Attorney paperwork been verified?	Yes	Date of verification	04.06.2025
		Name of verifier	Cara Alexander, DN
Is an Advanced directive in place (living will)?	No		
Is an Adult with Incapacity Section	No		

47 held?

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

Rehab Team Notes 08.01.25:
Remain at home where possible – discussion with family and Mrs Smith has taken place to identify additional support which would be necessary. Will link in with Respiratory Team to look at symptom management.

If condition deteriorates and Mrs Smith is unable to remain at home, care home would be considered. Mrs Smith understands that Sarah's role will change and does not wish to place burden on family.

Information Guidance Notes for preferred place of care

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

Rehab Team Notes 08.01.25:
Mrs Smith is anxious about hospital admission, due to past experience. Mrs Smith does not wish to be admitted to hospital or to receive any unnecessary treatments that prolong her life. If further decline in condition, Mrs Smith keen to try oral medications at home (or place of long term care).

Preferred place of death - at home (or place of long term care), not for admission to hospital.

Son and Daughter present for conversation and in agreement of all decisions made.

Has a Treatment Escalation Plan (TEP) ever been created for this person?	Yes

Date of TEP Creation	Hospital of Admission (if known)	Level of Escalation
16-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 (9)

v.10 - hospital discharge
17-Jun-25 09:18 by Maureen BOWERS
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