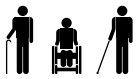
PROMEDICA24
Live-in companionship & care

ONE PAGE PROFILE



1. How should the person to be cared for in relation to their mobility?

2. What is the best way to communicate with the person?

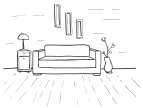
3. Has the person being cared for got any favourite things they like to use - ie mugs, plates, pilows, make up, slippers, etc.?

4. Has the person being cared for any preferences to how domestic tasks are done ie - washing, ironing, recycling?

5. Favourite food and drinks:

Dislikes:

Allergies:



6. In which room does the person to be cared for like best? Where do they like to sit or where do they like to take a nap? Where do they like to eat?

7. What kind of activities does the person to be cared for (at home and outside)?

8. Which TV program/s does the person being cared for want to watch most like? Do they like to listen to the radio?

9. What? Do they like reading the newspaper? Which?

10. What care needs does the person being cared for have?

Further important information regarding the person to be cared for:

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PREFERRED ROUTINES

PREFERRED ROUTINE		WEEK PLANNER	
Activities	Time of day	Day	Activity
 get up		Monday	
 breakfast		Tuesday	
 lunch		Wednesday	
 afternoon tea/cofee		Thursday	
 tea time		Friday	
 bed time		Weekend	

Personal hygiene (such as washing your hair, showering - when, how often?)

Shopping (Who does the shopping? How often? When? Where?)

Break time for the care worker:

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EMERGENCY CALL - HELP PLAN

ADDRESS OF THE PERSON TO BE CARED FOR:

CLIENTS DOB:

SOCIAL WORKER (if applicable):

DENTIST:

PHARMACIST:

DISTRICT NURSE:

SALT Team:

DNAR in place

FAMILY DOCTOR - CONTACT DETAILS:

FAMILY MEMBERS - CONTACT DETAILS:

24 hours - emergency number PROMEDICA24	Non emergency	Emergency
0118 321 44 62	111	999

LOCAL AUTHORITY SAFEGUARDING TEAM:

Version _____

My name: _____

I like to be known as: _____

People involved in writing this care plan: _____

People involved in my circle of support who I am happy to share information with: _____

BIOGRAPHY

1. SAFETY

What you need to know:

Areas of high risk for me:

What you must do to keep me safe:

Supported by a risk assessment? ☐ Yes ☐ No

2. MENTAL CAPACITY & MAKING DECISION

What you need to know about my ability to make decisions:

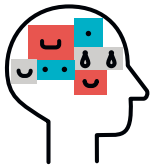
Is a mental capacity assessment needed? ☐ Yes ☐ No

Areas of high risk for me:

What you must do to keep me safe:

Supported by a risk assessment? ☐ Yes ☐ No

3. MEMORY



What you need to know:

What I can still do:

What I find difficult:

How you can help me to do the things I can still do and support me with the things I find difficult:

Supported by a risk assessment? ☐ Yes ☐ No

4. PERSONALITY

What you need to know:

How I am generally as a person, my disposition:

How I respond to new situations and difficulties:

What upsets me:

How you can support me to be positive and help me when I am distressed or withdrawn:

Supported by a risk assessment? ☐ Yes ☐ No

5. PHYSICAL HEALTH

What you need to know:

What I can still do for myself:

What I find difficult:

How you can help me with my physical health:

Supported by a risk assessment? ☐ Yes ☐ No

6. EATING AND DRINKING

What you need to know:

Things I enjoy:

Things I do not like:

How you can help me with eating and drinking:

Supported by a risk assessment? ☐ Yes ☐ No

7. SENSORY IMPAREMENT & COMMUNICATION

What you need to know:

My good senses are:

What I find difficult:

How you can help me make the best use of my senses:

Supported by a risk assessment? ☐ Yes ☐ No

8. SPIRITUALITY

What you need to know:

These are my beliefs, which are really important to me:

How you can help me to sustain them:

9. OCCUPATION, HOBBIES, LIFESTYLE

What you need to know:

This is what I like to be doing:

This is how you can help me to do it:

Supported by a risk assessment? ☐ Yes ☐ No

10. IN MY HOME

What you need to know:

The environment which best suits me is one where:

These are the challenges I have:

This is how you can support me to make the best of the world around me:

Supported by a risk assessment? ☐ Yes ☐ No

11. MY CIRCLE OF SUPPORT

What you need to know:

People and organisations which are important to me:

How you can support me with maintaining these relationships:

How you can support them to maintain a relationship with me:

12. ADVANCED CARE PLAN

What you need to know - what are my wishes?

How I would like others to be around me:

How you can support me:

OUTCOMES I WOULD LIKE TO ACHIEVE:

Desired Outcome	How Can This Be Achieved	People Involved

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RISK ASSESSMENT & MANAGEMENT

Date _____

Service User Name and Surname _____

Date of Birth _____

INDICATOR RISK	OBSERVATION/NOTES	PERSONS AT RISK	RISK	ACTION TO BE TAKEN
Gas Stop	Location:	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Trip Switch (Electric)	Location:	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Stop Cock (Water)	Location:	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Carbon Monoxide Detector - Placed near to gas boilers & Fires (If not in situ-high risk)	Location:	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Smoke Alarms (If not in situ-high risk)	Location: Working? ☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	

WORK ENVIRONMENT

INDICATOR RISK	OBSERVATION/NOTES	PERSONS AT RISK	RISK	ACTION TO BE TAKEN
Electric Wiring	Old Wiring? Safety Risk?	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Plugs & Sockets	Overloaded sockets? Frayed leads?	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Floor Coverings	Frayed Carpets? Rugs?	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Stairs	Does the Client use the stairs? ☐ Yes ☐ No ☐ Not Applicable	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	

INDICATOR RISK	OBSERVATION/NOTES	PERSONS AT RISK	RISK	ACTION TO BE TAKEN
Are escape routes free of combustible items/obstructions?	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Do escape routes lead to a place of safety?	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Is the Client Bed Fast? (in bed)	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Are there any sources of oxygen present? (oxygen cylinders)	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Does anyone in the household smoke?	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Are door fastenings simple to open without the need for a key?	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Pets	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Medication	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
Cleaning Materials	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	Only cleaning materials in their original containers with labels attached to be used.
Household Equipment **Microwave/Vacuum /kettle**	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	
	☐ Yes ☐ No	☐ Carer ☐ Client	☐ High ☐ Medium ☐ Low	

CARE SITUATION

Specialist Knowledge and Training Needed. Use of specialist equipment ☐ Yes ☐ No

EQUIPMENT	STAFF TRAINED	STORAGE	NOTES
Blister Pack ☐ Yes			
Nebuliser ☐ Yes			
Peg Feed ☐ Yes			
Stoma ☐ Yes			
Oxygen ☐ Yes			
Hoist ☐ Yes			
Stand Aid ☐ Yes			
Wheelchair ☐ Yes			
Slide Sheet ☐ Yes			

Bed Sides required? ☐ Yes ☐ No

Bed Sides count as restraint, are the Client/ Relatives and District Nurse/OT in agreement they can be used? ☐ Yes ☐ No

Is a Mental Capacity Assessment required? ☐ Yes ☐ No

RISK ASSESSMENT PLAN

IDENTIFIED RISK	ACTION	PERSON/ ORGANIZATION RESPONSIBLE	DATE TO BE COMPLETED BY	SIGNATURE

Assessment Completed by (please print name) **Paula Beaney**

Job Title **Quality Assurance Director**

Signature

Mental Capacity Act 2005
Record of Mental Capacity Assessment
(to be used in conjunction with the Mental Capacity Code of Practice)

Service User Name: _____

Location of Assessment: _____

_____

_____

Date of Birth: _____

NHS Number: _____

Date of Assessment: _____

Time of Assessment: _____

Mental capacity assessments should be completed by the most appropriate person relevant to the decision in question, e.g. care worker, social care practitioner, treating clinician, solicitor etc. The assessment should be carried out in an environment, at a time of day and in a way most conductive to the needs of the person being assessed.

1. DOES THE PERSON HAVE AN IMPAIRMENT OF, OR A DISTURBANCE IN THE FUNCTIONING OF, THEIR MIND OR BRAIN WHICH MAY AFFECT THEIR ABILITY TO MAKE A DECISION?

☐ Yes ☐ No

If **YES**, please state the nature of the impairment (e.g. dementia, acquired brain injury, learning disability, acute confused state, short-term memory loss; and the basis of this information (e.g. recent clinical assessments, established diagnosis, EMI (Elderly Mentally Infirm), specialist health/therapeutic provision). Complete section below.
If there is **NO** impairment or disturbance, they cannot be assessed to lack mental capacity under the Act.

2. WHAT IS THE DECISION (OR NATURE OF, THE DECISION) REQUIRED (E.G. TO MOVE FROM THEIR OWN HOME TO A CARE HOME, FINANCIAL AFFAIRS, CONSENT TO MEDICAL TREATMENT, ETC.)

3. DO YOU CONSIDER THAT THE PERSON MIGHT REGAIN OR ACQUIRE CAPACITY IN THE FUTURE IN RELATION TO THE DECISION THAT NEEDS TO BE MADE?

☐ Yes ☐ No

Please state why and give an indication of when this might happen:

4. IF 'YES', CAN THIS DECISION BE DELAYED UNTIL THEY ARE ABLE TO MAKE IT THEMSELVES?

☐ Yes ☐ No

Please explain reasons:

5.DESCRIBE WHAT STEPS YOU (OR ANY OTHER PERSON) HAVE TAKEN TO ENABLE THE PERSON TO MAKE THE DECISION THEMSELVES

(e.g. use of an interpreter or communication aids, ensuring they have all relevant information in an accessible form, treating a medical condition that may be affecting the persons capacity, considering times of day when their understanding is better, involving someone who knows them, and they trust to communicate information, etc.)

On the date given above and in relation to the decision described:

1. IS THE PERSON ABLE TO UNDERSTAND THE INFORMATION RELEVANT TO THE DECISION?

(i.e. were you satisfied that the person could understand the nature of the decision, why the decision needed to be made at the time and whether they could understand the likely effects of deciding one way or another or making no decision at all?)

☐ Yes ☐ No

Please give reasons:

2. IS THE PERSON ABLE TO RETAIN THE INFORMATION LONG ENOUGH TO USE IT TO MAKE THE DECISION?

(i.e. long enough to complete the decision-making process, including making and communicating their decision. Consideration should be given to the use of notebooks, photographs, videos, voice recorders, posters etc. to help the person record and retain the information)

☐ Yes ☐ No

Please give reasons:

3. IS THE PERSON ABLE TO USE OR WEIGH UP THIS INFORMATION AS PART OF THE DECISION MAKING PROCESS?

(e.g. to consider the consequences, benefits and risks, of making the decision one way or another or making no decision at all? Understand the pros and cons)

☐ Yes ☐ No

Please give reasons:

4. IS THE PERSON ABLE TO COMMUNICATE THEIR DECISION?

☐ Yes ☐ No

Please give reasons:

In order to establish that someone does not have the mental capacity to make a particular decision the assessor must have a reasonable belief (i.e. on the balance of probabilities) that they lack mental capacity.
An answer of **'No'** to any one of these four questions indicates that the person lacks mental capacity to make the decision in question. If the answer is **'YES'** to all the above four questions, the person must be assessed to have the mental capacity to make the decision themselves.

ASSESSMENT

Based on the above information, my judgement is that

_____

(Name of person being assessed)

Has the mental capacity / Does not have the mental capacity (delete as appropriate) to make a decision regarding:

_____

(State Decision / Nature of Decision here)

Name of Assessor (print name): **Paula Beaney**

Signature: _____

Job Title: **Quality Assurance Director**

Everyone who works with or provides support to an adult who may have compromised mental capacity must be familiar with, and apply, the five key principles of The Mental Capacity Act.

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

For further information or advice regarding the Mental Capacity Act or if you have any comments or questions about this form contact the local Safeguarding Lead.

Date _____

Service User Name and Surname _____

Date of Birth _____

Medication Requirements		Specific Details
Able to Self-Medicate	☐ Yes ☐ No	
Prompting from Care Worker is required	☐ Yes ☐ No	
Medication is to be administered by Care Worker	☐ Yes ☐ No	

ALLERGIES

CREAMS/LOTIONS

PHARMACY ARRANGEMENTS (e.g. how order is placed, collection, delivery, etc)

MEDICATION STORAGE

CURRENT MEDICATION

Medication	Dose	Directions/Instructions/purpose	Contraindications if missed/refused

Assessment Completed by (please print name) **Paula Beaney**

Job Title **Quality Assurance Director**

Signature _____

CURRENT MEDICATION

Medication	Dose	Directions/Instructions/purpose	Contraindications if missed/refused

Assessment Completed by (please print name) **Paula Beaney**

Job Title **Quality Assurance Director**

Signature _____

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RISK ASSESSMENT FOR MEDICINES MANAGEMENT

Date _____

Service User Name and Surname _____

Date of Birth _____

		SAFE SYSTEM OF WORK (to include control measures, and any other relevant information)
Is there a current medication list on record for the service user?	☐ Yes ☐ No ☐ N/A	
Are all medicines clearly labelled?	☐ Yes ☐ No ☐ N/A	
Do the labels correspond with the current medication list?	☐ Yes ☐ No ☐ N/A	
If the family is involved in ordering or assisting with medication, is this still appropriate?	☐ Yes ☐ No ☐ N/A	
Are all non-fridge medicines kept in a cool, dry place in their original containers, including creams etc?	☐ Yes ☐ No ☐ N/A	
Are medicines requiring low temperature storage kept in the refrigerator?	☐ Yes ☐ No ☐ N/A	
Are any aerosol medicines/pressurised containers kept away from heat sources?	☐ Yes ☐ No ☐ N/A	
Are all medicines within their expiry dates?	☐ Yes ☐ No ☐ N/A	
Has expired and unwanted medication been removed from the premises?	☐ Yes ☐ No ☐ N/A	
Is it safe for the service user to have access to their medications? E.g. to reduce the risk of overdose etc	☐ Yes ☐ No ☐ N/A	
If relevant, is the service user aware of the risks associated with use of large quantities of liquid or white soft paraffin products?	☐ Yes ☐ No ☐ N/A	
As - required medicines - Are there clear instructions regarding when they are to be used, the correct dose and maximum daily dose or minimum frequency?	☐ Yes ☐ No ☐ N/A	
Do all medicines have the same dose at the same time every day? (e.g. for weekly or monthly doses, reducing or otherwise changing doses answer 'No')	☐ Yes ☐ No ☐ N/A	

		SAFE SYSTEM OF WORK (to include control measures, and any other relevant information)
Warfarin – is the yellow book or latest blood test result and dosage instruction always available?	☐ Yes ☐ No ☐ N/A	
Patches - Are there clear instructions regarding: - How to apply them - How often to change them - Where on the body to place them - Whether this needs to be moved around the body - Do staff have a clear method of recording when the previous patch was removed	☐ Yes ☐ No ☐ N/A	
Liquid Medicines, sachets, granules: - Is the most appropriate measure available for use, i.e. 5ml spoon or oral syringe of the nearest size to the dose to be given?	☐ Yes ☐ No ☐ N/A	
Are all medications presented as tablets to be swallowed whole? e.g. for sublingual tablets, sprays, patches, melts, oro-dispersible tablets, buccal tablets, suppositories or pessaries, answer **"No"**	☐ Yes ☐ No ☐ N/A	
Any of the hazardous medicines? These should be managed carefully and should not be administered by pregnant women	☐ Yes ☐ No ☐ N/A	
Other hazard? Please specify (e.g. security risk)	☐ Yes ☐ No ☐ N/A	

Assessment Completed by (please print name) **Paula Beaney** _____

Job Title **Quality Assurance Director** _____

Signature _____

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PERSONAL EMERGENCY EVACUATION PLAN (PEEP)

Date _____

Service User Name and Surname _____

Date of Birth _____

What physical disability or concern is likely to make evacuation difficult? Is this a permanent condition?

ARRANGEMENTS FOR EVACUATION

What equipment or methods are required to assist during the evacuation process:	
Description of how evacuation will be completed:	
How many people are required to successfully evacuate Service User?	
If Service User can't be moved because of complexity of presentation, what must Care Worker do prior to leaving the Service User?	

Assessment Completed by (please print name) **Paula Beaney** _____

Job Title **Quality Assurance Director** _____

Signature _____

PROMEDICA24
Live-in companionship & care

EMERGENCY CARE PLANNING

Date _____

Service User Name and Surname _____

Date of Birth _____

EMERGENCY PLANNING IN THE EVENT OF A CARE WORKER NOT BEING AVAILABLE AT SHORT NOTICE

RISK IDENTIFIED
REASON(S) WHY RISK OCCURS
HOW RISK WILL BE MANAGED

Assessment Completed by (please print name) **Paula Beaney** _____

Job Title **Quality Assurance Director** _____

Signature _____

1. In the case of an agreement concluded by a service user himself/herself:

We hereby inform that the consent may be withdrawn at any time by sending an email to: **dataprotection@promedica24.co.uk** or by phone by calling: **+44 20 3318 5475**. Withdrawing your consent will not affect the compliance with the right to process data, if such processing was performed before the consent was withdrawn

Consent to the processing of health data

I hereby give my consent to the processing by the company Promedica24 (Wiltshire) Ltd

of the personal data regarding my health, for the purposes of preparing and performing a care services agreement.

☐ yes, I consent ☐ no, I do not consent .....
(date and signature)

Consent to marketing
I hereby agree to receive from Promedica24 UK Ltd in Watford, via email, SMS/MMS and by phone the marketing content containing information about the Promedica24 Group services, consumer research, contests, promotions and events organized by the entities belonging to the Promedica24 Group.

☐ yes, I consent ☐ no, I do not consent .....
(date and signature)

2. AGREEMENT CONCLUDED BY A legal representative (Where a person lacks capacity in line with the MCA 2005)

We hereby inform that the consent may be withdrawn at any time by sending an email to: **dataprotection@promedica24.co.uk** or by phone by calling: **+44 20 3318 5475**. Withdrawing your consent will not affect the compliance with the right to process data, if such processing was performed before the consent was withdrawn.

Consent to the processing of health data of a service user (in the case the service user is a party to the agreement)

I hereby agree to the processing of personal data, including health data, of

.....
(full name of the service user),

in order to prepare and perform the agreement for the provision of care services.

I hereby declare that I am authorised to submit the above statements regarding the processing of personal data.

☐ yes, I consent ☐ no, I do not consent .....
(date and signature)

Consent to the processing of the ordinary data of a legal representative (service users's representative gives his/her contact details that will be used during the term of the agreement).

I hereby give my consent to the processing of my personal data by the company Promedica24 (Wiltshire) Ltd

in order to perform the agreement provided for the benefit of the person I am a legal representative of.

☐ yes, I consent ☐ no, I do not consent .....
(date and signature)

Marketing consent for the processing of the ordinary data of a legal representative

I hereby agree to receive from Promedica24 UK Ltd in Watford, via email, SMS/MMS and by phone the marketing content containing information about the Promedica24 Group services, consumer research, contests, promotions and events organized by the entities belonging to the Promedica24 Group.

☐ yes, I consent ☐ no, I do not consent .....
(date and signature)

The administrator of your data is:

- Promedica24 (Wiltshire) Ltd

in connection with the conclusion and implementation of the agreement for the provision of care services;

- Promedica24 UK Limited in Watford - in case of giving marketing consents.

Detailed information on the protection of personal data can be found on the website https://www.promedica24.co.uk.

For more information on the processing of your data, you can contact the Data Protection Officer: dataprotection@promedica24.co.uk.

Your personal data will be processed in order to prepare an offer and perform an agreement for the provision of care services (also applies to the contact person); in the case of marketing consent, your data will also be processed to provide you with marketing content. In addition, your personal data will be processed for the purpose of sending occasional materials and regarding ongoing cooperation established under this agreement. Providing data is voluntary, yet necessary for the preparation and performance of the agreement for the provision of care services or for the implementation of marketing targets.

We process your personal data, because:
- the data is necessary for our performance of a contract with you,
- you have consented to our use of your personal data, or
- it is in our legitimate business interests to use it. Our legitimate interest of is to build positive customer relations and promote our marketing.

Access to your data will be provided to our employees, representatives and other entities from the Promedica24 Group cooperating with our company, as well as entities not belonging to the Promedica24 Group rendering IT, telecommunications, marketing and logistic services to our benefit, which support us in our operations. These entities will have access to your data only for the purpose of proper performance of the agreement or marketing purposes. Your data will also be processed by entities operating in the United States of America, supporting us in the area of information technology and telecommunications. These entities have joined the Privacy Shield program, approved by the European Commission, which means that they properly protect personal data.

Your data will be stored:
- in the case of data processed in connection with the need to take action before the conclusion of the agreement and the implementation thereof, as well as the data concerning health processed on the basis of consent – after the termination or expiry of the agreement,

and when no agreement is concluded, in relation to the legitimate interest of the company Promedica24 (Wiltshire) Ltd

involving the need to store data for the possible defence against claims, no longer than required by applicable law. The period of the storage of personal data also applies to the storage of data of the contact persons.

- In the event of the withdrawal of the consent to receive marketing information, the data will be stored no longer than required by applicable law regarding the limitation of claims.

You have the right to:
- request access to personal data, rectification, deletion or limitation, as well as the right to object to the processing and to transfer data;
- withdraw your consent to the processing of data or receive marketing content at any time, by sending an email to the following address: dataprotection@promedica24.co.uk or by phone by calling: +44 20 3318 5475, alternatively in writing. Withdrawing your consent will not affect the compliance with the right to process data, if such processing was performed before the consent was withdrawn
- submit a complaint to the supervisory body regarding the processing of your personal data by us:

Contact Details for ICO

Helpline No. 0303 123 1113 (open Mon-Fri 9am to 5pm).
postal address: Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

https://ico.org.uk/concerns/

Your data will not be used for profiling or making automated decisions.