What does this mean for patients and carers?

Once the care plan has been agreed the patient will be given a copy of the care plan to keep safe in their home. It is important for patients and their carers to tell other healthcare professionals that they have a care plan and show it to them, so that if they become ill they can see what actions were agreed between the patient and the GP to best manage these situations.

Reviewing the care plan

If a patient with a care plan is unfortunately admitted to hospital as an emergency or needs to attend A&E, the patient's practice will undertake a review of what happened so they can understand why the admission or attendance occurred and whether it could have been avoided, taking actions to ensure it doesn't happen again.

A patient or carer can also advise their GP of any changes or updates that they feel could be included in their care plan.

If you think you, or your loved one would benefit from having a care plan in place please contact your GP practice to discuss it.

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Using a care plan to help avoid being admitted to hospital

Patients, Practices, Partners

Developing a care plan to help you or a loved one avoid a health crisis

Do you feel that you or your loved one need more support to remain as well as possible and to avoid the risk of getting into a crisis situation, which means you may result in being admitted to hospital urgently?

Working with you or your family member to produce a care plan can give you peace of mind and reduce your risk of being admitted to hospital, when it can probably be avoided.

What does a care plan involve and how is it developed?

Patients identified as vulnerable and being at high risk of an unplanned admission to hospital will be assigned a named accountable GP. This GP will have overall responsibility for coordinating the patients care and will develop a personalised care plan, working together with the patient and their carer (if applicable), detailing how their ongoing health and care needs will be addressed to reduce their risk of an avoidable admission to hospital. The discussion regarding the care plan can take place at the practice, in the patient's own home or in a care home.

Information contained within the care plan can include;

- Relevant medical information; conditions, diagnosis and latest test results
- Details of medication
- Anticipated emergencies
- Resuscitation status
- Consent to share information
- Significant past medical history
- Anticipatory prescribing
- Information for the Out of Hours service and ambulance paramedics