Health Quality Ontario

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June 12, 2018

Coordinated Care Plan User Guide Version 2.1

HealthLink

Ontario
Health Quality Ontario

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User Guide Introduction

This document describes how the coordinated care plan (CCP) template is intended to be used and the purpose of each individual information field that is part of the CCP. A "user" of the CCP could be a provider documenting the plan, a clinician viewing the plan, and the patient or substitute decision maker (SDM). In all cases, the user(s) and not HQO is/are responsible for ensuring the template is used in accordance with all applicable laws including those related to privacy and health care consent. Health Quality Ontario is not responsible for any losses, claims, damages or fees that arise in connection with any person or entity's use of this form or reliance on its content. Users should obtain independent legal advice. The descriptions in this guide allow users to develop a common understanding of how to populate the template so CCPs can be used consistently and reliably in clinical settings.

Purpose of the Coordinated Care Plan

Coordinated care plans have evolved into a communication tool for patients, their families/caregivers, and providers. Where they were once a detailed care plan, they are now intended to streamline coordinated, collaborative approaches to meeting the patient's goals and support holistic care across programs, organizations, and sectors. This is a living document that requires regular review and updates driven by changes to the patient's status.

Guiding Principles

The following guiding principles are to encourage consistent use of CCPs:

- The CCP reflects the patient's stated values, beliefs, goals, needs, and preferences with a holistic perspective.
- Each CCP is developed through collaboration between providers, patients, caregivers, and substitute decision-makers where appropriate.
- Coordinated care plans are based on current evidence and use generally accepted clinical guidelines.
- The CCP has core components and optional modular components in the appendices.
- The CCP is written in clear language, using the patient's own words where possible.
- The patient is given a copy of the CCP or has access to the information included in the plan.
- Coordinated care plans are accessible to the circle of care in any setting where care may be delivered. The patient can determines who specifically needs a copy or access to the CCP.
- Coordinated care plans are actively maintained according to the practices established in each Health Link by all in the circle of care. It is a living document that requires revisions and communication of these revisions.
- Each user, healthcare provider or organization, as the case may be, is responsible for obtaining all necessary consents from patients or their SDMs as required by law and for seeking local guidance if and when required.
- The healthcare provider completing the form, is expected to comply with all applicable laws including those related to privacy and health care consent

CCP Template Information Fields

This guide applies to CCP template version 2.1.

CCP Header

This section labels each page of the CCP with the patient's name, the name of the person who last updated the CCP and the associated date of the update.

Information Field	What it tries to capture	How to fill it out	Key questions
Patient's name	The patient's full names	Free text	
Last updated by	The name by which the person who last updated the CCP	Free text	
Last updated date:	The date the CCP was last updated	Use the format YYYY-MM-DD	

CCP Footer

This section has a confidentiality note and documents printing information.

Information Field	What it tries to capture	How to fill it out	Key questions
Copy – Confidential document, to be disposed of in a secure manner			
Date printed	Date the CCP is printed	Use the format YYYY-MM-DD	
Printed by	The name by which the person who printed the CCP	Free text	
Page	Page numbering	Automatic	

My Identifiers

This section helps to establish the identity of the patient by providing both basic information about him/her (e.g., name, date of birth, address, etc.). As well, it highlights accommodations to ensure effective communications.

Information field	What it tries to capture	How to fill it out	Key questions
Given name	The patient's given name	Free text	
Preferred name	The name by which the patient prefers to be identified	Free text	*Do you prefer to be called by a different name?*
Surname	The patient's surname or family name	Free text	*What is your last name?*
Date of birth	The patient's date of birth	Use the format YYYY-MM-DD	
Gender	The patient's identified gender	Free text	
Preferred pronoun	The patient's preferred pronoun	Free text	*What pronoun should we use to address you?*
Address	The address of the patient's primary residence	Free text	
City	The city of the patient's primary residence	Free text	
Province	The province of the patient's primary residence	Drop-down menu	
Options	Description		
AB	Alberta		
BC	British Columbia		
MB	Manitoba		
NB	New Brunswick		

Information field	What it tries to capture	How to fill it out	Key questions
NL	Newfoundland		
NS	Nova Scotia		
NT	North West Territories		
NU	Nunavut		
ON	Ontario		
PE	Prince Edward Island		
QC	Quebec		
SK	Saskatchewan Yukon		
YT	Other		
Other			
Postal code	The postal code of the patient's primary residence	Standard six-character format	
Health card number	The patient's health card number	Free text	
Issued by	The province where the health card was issued	Drop-down menu	
Options	Description		
AB	Alberta		
BC	British Columbia		
MB	Manitoba		
NB	New Brunswick		
NL	Newfoundland		
NS	Nova Scotia		
NT	North West Territories		
NU	Nunavut		
ON	Ontario		
PE	Prince Edward Island		
QC	Quebec		
SK	Saskatchewan		
YT	Yukon		
Other insurance	The patient is covered by an alternate insurance plan		
Uninsured	The patient is not covered by an insurance plan		
Unknown	The patient is unsure of their coverage		
Decline to answer	The patient declines to answer		
Ancestry/culture	The patient's ancestry/culture	Free text	

Information field	What it tries to capture	How to fill it out	Key questions
Identify as First Nations, Metis, or Inuit?	Whether or not the patient identifies as First Nations, Métis, or Inuit	Dropdown menu: Yes, No, Unknown, Decline to answer	
If "yes", specify which nation?	Which nation the patient identifies with	Free text	
Language of comfort	The language in which the patient feels most at ease communicating	Free text	
Communication accommodations	The patient's hearing, vision, speech, learning, language, and developmental accommodations	Free text	*How can we help you communicate about your health? Do you require any accommodations?*

What's Most Important To Me and My Concerns

This section is intended to ground the subsequent conversations with patients in their priorities and concerns. The identified priorities and concerns are not restricted to their personal health. The information identified here should be used to contextualize the health and social information that is gathered in the subsequent sections and applied to the action plan at the end.

Information field	What it tries to capture	How to fill it out	Key questions
What is most important to me right now	The single highest priority of the patient both within and outside the context of their health	Free text	*In your overall life, what is most important to you? It may or may not be health related. What parts of your day do you look forward to the most? What is really important to you and your family?*
What concerns me most about my health care right now	The single greatest concern of the patient within the context of their health	Free text	*What is most concerning about the state of your health care?*

My Care Team

This section records the members of the patient's care team, including both clinical providers and service providers and caregivers (family members or friends supporting the patient with their health care), and provides some information to describe each member's role in the care team.

Where possible, document individual names should be identified; if individuals are not identified, document the name of the organization (e.g., a retail pharmacy). In this section include active specialists, foot care clinics, eye clinics, dental teams, community service providers, and caregivers not listed as substitute decision makers.

Information Field	What it tries to capture	How to fill it out	Key questions
Coordinating lead	The first and last name and phone number of the provider that is the main point of contact. This individual coordinates care and keeps the care plan up to date.	Free text	
Name of team member	First and last name of team member	Free text	
Role	The care team member's professional role or relationship to the patient.	Free text	
Organization	If applicable, the organization with which the care team member is affiliated	Free text	
Contact information—primary	The care team member's primary telephone number	Use the format XXX-XXX-XXXX	
Contact information—secondary	The care team member's secondary contact information (e.g., fax or telephone number)	Free text	
Share coordinated care plan?	Whether or not the CCP is to be shared with associated providers or caregivers is up to the patient to decide. The patient can provide a copy of the CCP to any individual they choose. Ensure that you have obtained all necessary consent to collect, use, and disclose the patient's personal health information from the patient or the SDM authorized under PHIPA. If you are sharing the CCP, ensure that you have the proper legal authority to disclose under PHIPA.	Drop-down menu: Yes, No, or blank *Blank means "unknown," and should be clarified with the patient*	*Which of the identified team members would you like me to share this plan with?* *Do you think you will share this plan with your family/caregivers?*

Health Care Consent and Advance Care Planning

When a patient is unable to provide consent, here is the list of substitute decision makers (SDMs) for their health care, their relationship with the patient, and their contact information.

Information Field	What it tries to capture	How to fill it out	Key questions
Note: Ensure that you've obtained all necessary consents to treatment from the patient or the SDM as required by law.			
Name	The SDM's full name, first and last.	Free text	
Relationship	The relationship to the patient	Free text	
Type of SDM	Where the identified substitute decision maker is on the hierarchy list according to the applicable legislation Under the Health Care Consent Act, 1996, an SDM must be the highest in the ranking and must meet all the statutory requirements in order to consent or refuse to consent to treatment on an incapable person's behalf. The hierarchy of persons who may give or refuse consent to treatment as set out in the HCCA.	Drop-down menu	
Options	Description		
	1. Guardian of the person, with authority for treatment decisions 2. Power of Attorney for personal care, with authority for treatment decisions 3. Representative appointed by the Consent and Capacity Board with authority for treatment decisions 4. Spouse or partner 5. Child or parent or Children's Aid Society or other person who is lawfully entitled to make treatment decisions in place of the parent 6. Parent with only a right of access 7. Brother or sister 8. Any other relative 9. Office of the Public Guardian and Trustee		

Contact information—primary phone no.	The primary phone number for the contact listed above as the first person to call for consent due to incapacitation	Free text
Contact information—secondary phone no.	The secondary phone number for the contact listed above	Free text
I have shared my wishes, values, and beliefs with my future SDM as they relate to my future health care	The patient confirms that he/she has informed their SDM of their wishes, values, and beliefs when they are unable to make their own decisions.	Drop-down menu
Options	Description	
Yes	The patient has informed their SDM.	
No	The patient has not informed their SDM.	
Unsure	The patient is unsure if they have informed their SDM.	
Note: If the patient answers "No" to the question "I have shared my wishes, values and beliefs with my future SDM as they relate to my future health care?", provide advance care planning (ACP) provincially approved resources (e.g. "Speak-Up Ontario ACP Workbook" or website information www.speakupontario.ca).		

My Health

This section records the various conditions, issues, and/or diagnoses that are affecting the patient. This may include physical, mental health, or addictions (such as smoking, alcohol, drugs, or gambling) issues. This section lists the issues with details including onset and considerations.

Information field	What it tries to capture	How to fill it out	Key questions
Issues	Describe the condition, issue, and/or diagnosis the patient identifies as part of the discussion on what challenges they have with their health Use one line for each condition identified. These conditions can be physical, or psychological.	Free text	*Do you have any challenges with your health?* *What kinds of activities do you do each day? Do you have any difficulty completing these activities? What are your current diagnoses?*

Details (onset, considerations)	List clinical history and current treatments in place for each condition or issue identified and the date of onset if known.	Free text.	*Tell me about your journey with this diagnosis/condition.* *When were you first diagnosed? What tests or procedures have you had?*

More About Me

This section captures the social determinants and other factors that may affect the coordination of health and care. The effect of the information on the patient's health and care is the focus of the data, rather than the information itself (e.g., impact of income, rather than magnitude of income).

To help facilitate the conversation, a suggested script is provided below:

"We now know that social health is just as important to people's well-being as their physical and mental health. Social health includes things like transportation, income, food security, and social supports. Part of what makes this care plan unique is that we look to this information to help support your whole health needs. In this section we're going to talk about some of these social determinants of health and other factors that may impact the coordination of your health and care."

Information field	What it tries to capture	How to fill it out	Key questions
Income	If the patient's income is adequate for their health. If the patient states that income is a concern, then review current income and benefit sources. Highlight possible sources for follow-up. Here are some examples: • Canada Pension Plan (CPP) • Old Age Security • Guaranteed Income Supplement (GIS) • Canada Pension Plan Disability (CPPD) • Veteran's Benefits	Free text	*Do you have difficulty making ends meet at the end of the month?* *Have you recently been unable to fill your prescription, or unable to get to your doctor's appointment, or unable to purchase your food?* *If the patient if having difficulty making ends meet, then ask about their sources of income. "I don't need to know how much your income is, just the sources of income to see if other resources are available."*

	• Guaranteed Annual Income System (GAINS) • Ontario Works • Ontario Disability Support Program (ODSP) • Trillium Benefits • Ontario Drug Benefit (ODB) • Non-Insured Health Benefits (NIHB) • Indian Status Card • Special Services At Home (SSAH) • Private insurance • Employee pension		
Employment	If the patient is currently employed or if they worked in the past, what kind of work did they do? Does it relate to their current health conditions (if at all)	Free text	*Are you currently employed or have you worked I the past? What type of work did you do? Can you tell me about that?*
Housing	What is the patient's current housing situation? Is the housing safe, affordable, accessible and stable? Are there people or animals depending on the patient?	Free text	*Do you live with people/animals who depend on you?* *How long have you been in your home?* *Are you able to access all areas of your home or are there challenges in some areas?* *Do you feel safe here?* *Is your home affordable?*
Transportation	The current method of transportation and if there are any challenges accessing transportation to attend appointments or work.	Free text	*How do you get to and from your appointments? Do you feel this is working well considering cost, caregiver availability and your physical abilities to attend your appointments?*
Food security	Document the patient's ability to access affordable food and their knowledge of healthy eating habits.	Free text	*How do you get your groceries? How do you prepare your meals?*

			Do you feel you have adequate food to support your health? Do you have the right kinds of food to support your health? *Have you ever accessed food banks? If so, where and how often?*
Social network	Document the kinds of activities the patient participates in daily, weekly, or monthly in terms of social activities, either in the community or with family and friends.	Free text	*When you are feeling well, what types of activities do you enjoy?* *Do you have a spouse or partner? If so, how long have you been together? Do you feel safe with your partner?* *Do you regularly see caregivers, family, and friends? Do you feel supported?* *How do you spend your days?* *How often do you get out of your home?* *Where do you like to go? Are you able to get outside every day?* *Do you have any big events taking place this year?* *Do you ever feel lonely?*
Health knowledge	Document the patient's level of understanding of reading material and their ability to fill out forms necessary for their health	Free text	*Do you understand your diagnosis, treatment plan, and prognosis* *How confident do you feel reading and understanding information about your health?* *How comfortable are you completing forms for health services or information regarding your health?*
Newcomer to Canada	Document whether the patient is a newcomer to Canada.	Free text	*Were you born in in this country?* *If not, how long have you been in Canada?*

Legal	Document if the patient requires legal resources.	Free text	*Do you have legal concerns affecting your health? For example government forms (taxes, health card or social insurance numbers) or police issues.*
Spiritual affiliation	Document the patient's spiritual preferences	Free text	*What is your spiritual affiliation/preference?*
Caregiver issues	Document if the patient feels that support around caregivers would be beneficial.		*Do you think that your caregiver feels stressed? Is there anything that we could do to help to support them?* *Do you feel safe in your home and with your caregiver?*
Blank row	Document other items that the patient identifies that may impact their health or well-being.	Free text	*Are there other things that you would like to share with me that I have not asked about?*

My Goals and Action Plan

This section lists the patient's current goals, and the action plan relating to those goals.

Information field	What it tries to capture	How to fill it out	Key questions
What I hope to achieve	Document the patient's identified goals. This conversation should take place after completing the previous section, which should highlight areas where the patient needs assistance in terms of either health or social determinants of health.	Free text	*What are the top 3 things you want to focus on?*
What we can do to achieve it	The actions that the care team will take to accomplish those goals. List proactive follow up actions.	Free text	*What are some steps we can take to work toward this goal?* Are there people or services missing from your care team? Do you have good relationships with your care team members?

Details	Document how barriers are accommodated	Free text	
Who will be responsible	The names of care team members who will be responsible for completing the actions described	Free text	*Who do you want to help you do this?*
Date goal identified	Document initial identification of goal	Use the format YYYY-MMM-DD	

My Medication Coordination

This section records the support components of organizing medications, such as medication contacts, medication reconciliations, and how the patient manages challenges to taking medications. The section also reminds the provider that, if more appropriate, a medication list can be attached, or the medication list in the appendix can be completed.

Information Field	What it tries to capture	How to fill it in	Key questions
Most reliable source for medication list (e.g., primary prescriber, medication manager, family member)	Document who is the most reliable source of information regarding the patient's medications (e.g. the patient, a family member, primary care provider, or the local pharmacy).	Free text	*Who prescribes your medications?*
Aids I use to take my medications	Document any aids the patient uses to take medications.	Drop-down menu	
Options	Description		
Blister pack **Pill box organizer**			
If someone helps you with medications, who helps you?	List the names of those who support the patient with the administration, pick-up, and/or delivery of medications	Free text	*Does anyone help you take your medication?*
Challenges I have taking my medications	Document any challenges the patient has with taking medications, include physical or financial challenges.	Free text	*Do you have any difficulty taking your medications? Can you afford the medications and the dispensing fees?*

My Allergies

This section records the patient's allergens and allergic symptoms.

Information field	What it tries to capture	How to fill it out	Key questions
No known allergies	If selected, it indicates that the patient has no known allergies.	Check box	
What are you allergic or intolerant to?	If applicable, list the patient's allergies or intolerances	Free text	
What happens to you? What are your symptoms?	If applicable, describe the signs and symptoms the patient experiences when exposed to allergies and intolerances	Free text	

Appendices Attached

The care plan has modular options and this section records which appendix sections are being included in the care plan.

Information field	What it tries to capture	How to fill it out	Key questions
Medication list	See section below	Free text	
My health assessments	See section below	Checkbox	
Most recent hospital visit	See section below	Checkbox	
Palliative approach to care	See section below	Checkbox	

CCP Appendices

Four appendices have been added to this version of the CCP. They are intended to be modular and not all may be used for every patient. It is up to the provider, who is informed by the patient/caregiver, to determine which, and if, these additional appendices are necessary for the coordination of care for each patient.

My Medication Lists

This section lists current medications, providing details such as drug name, method of drug delivery, the pharmacy that provides the drugs, and the prescriber's name. The start dates and change dates create a chronology of the patient's medication usage and how it may have changed over time. Note: it is recommended you obtain the most recent medication reconciliation from provider/source (e.g. pharmacy, hospital, primary care) where it was most recently completed.

Information Field	What it tries to capture	How to fill it in	Examples and/or key questions

Drugs/medicine	The generic or trade name of the drugs identified by the patient or provided on a list.	Free text
Dose	The strength or dose of the medication	Free text
How often am I taking this medication?	Document how often the medication is taken.	Free text
Why am I taking it?	Document why the medication is taken both from the patient perspective and from a prescriber perspective	Free text
Who prescribed the medication?	Name provider	Free text
When did I start taking this medication?	Document when the patient remembers starting the medication.	Use the format YYYY-MM-DD
Prescriber	Document who prescribed the medication	Free text
Notes	Document any other information provided by the patient or the prescriber as appropriate.	Free text

My Health Assessments

This section lists the health assessments completed and notes that may help inform the care plan.

Information field	What it tries to capture	How to fill it out	Key questions
Assessment type and name	The name and type of the particular assessment that was conducted for the patient.	Free text	
Date completed	The date that the most recent instance of said assessment was completed	Use the format YYYY-MMM-DD	
Notes	What information was gained from the assessment that can be used to support the development of the action plan?	Free text	

My Most Recent Hospital Visit

This section provides some information about the patient's most recent hospital admission or emergency room visit. The section captures the hospital name and visit details.

Information field	What it tries to capture	How to fill it out	Key questions
Hospital name	The name of the hospital where the patient most recently visited the ED or was admitted (not meant to capture outpatient visits)	Free text	
Visit date	The date that the visit started	Use the format YYYY-MM-DD	
Reason for visit	A plain-language description of the reason for the visit	Free text	
Visit description	Was the patient admitted to hospital or seen in the emergency room and sent home.	Check correct box: "emergency room to home" or "emergency room to inpatient unit"	
Date of discharge	The date that the patient was discharged from hospital	Use the format YYYY-MM-DD	
Length of stay	The total number of days the patient stayed in the hospital	Free text	
Comments	Identify any changes to the patient's status in the hospital that could affect them or their care team after discharge.	Free text	*Did the hospital stay impact the progress of your goals?*

Palliative Approach to Care

This section is for customizing the patient's palliative approach to care.

Information field	What it tries to capture	How to fill it out	Key questions
The person most responsible for my palliative care	The individual(s) most responsible for the patient's palliative care. This person may be different from the Coordinating lead identified in the *My Care Team* section. It could be both a family member and provider.	Free text	*Who is helping to coordinate palliative care at home? Your advocate?* *What provider is helping coordinate palliative support?*
Physical support plan—symptoms	Document the symptoms that the patient experiences with pain, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, and drowsiness, and the associated actions to manage these symptoms.	Free text (one item per row)	*How are you feeling physically?*
Physical support plan—treatments	Document the treatments in place to support the patient with pain management, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, and drowsiness	Free text	*Discuss support options and the patient's preferences.*
Physical support plan—comments	Document any information that may impact the treatment of the patient who experiences pain, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, and drowsiness	Free text	*What do you prefer? What works for you?*
Psychological support plan—symptoms	Document the symptoms that the patient experiences while emotional, anxious, depressed, fearful, and controlling.	Free text	*How are you feeling emotionally?*
Psychological support plan—treatment	Document the care plans in place to support the patient with anxiety, depression, autonomy issues, fear, control, and low self-esteem.	Free text	*Discuss support options and the patient's preferences.*

Information field	What it tries to capture	How to fill it out	Key questions
Psychological support plan—comments	Document any information that may impact the treatment of the patient who experiences anxiety, depression, autonomy issues, fear, control, and low self-esteem.	Free text	*What do you prefer? What works for you?*
Social support plan	Describe the patient's relationships, including family caregivers, volunteers, environment, financial, and legal	Free text	*What family/friend supports do you have available?*
Spiritual support plan	Describe the patient's spiritual support plan.	Free text	*Do you have a religious/spiritual group you meet with regularly? Is there someone there you want us to contact to support you?*
Preferred place of death	Identify the patient's preferred place of death.	Free text	*Have you discussed where you would prefer to pass away?*
Grief and bereavement support	If applicable, identify the patient's grief and bereavement plan.	Free text	*How are you copying with grief?* *How is your family copying?*
Other	Document additional supportive items		

Appendix

The following is an example of a completed CCP.

HealthLink

Roberta Franklin's Coordinated Care Plan	
Last updated by: Debbie Smith	Last updated date: 2017-05-31

Note: This template must be completed in conjunction with the Coordinated Care Plan user guide.

My Identifiers

Given name: **Roberta**	Preferred name: **Roberta**	Surname: **Franklin**	
Date of birth: **1927-02-23**	Gender: Female	Preferred pronoun: **She**	
Address**: Maintown Retirement Home, Apartment 4a**			
City: **Maintown**	Province: **ON**	Postal code: M5V8B2	
Telephone number: **647-555-5555**	Alternate telephone number:		
Health card number: **111111111 RV**	Issued by: **ON**	Ancestry/culture: **Canadian**	
Identify as First Nation, Métis, or Inuit? **No**	If "yes," specify which nation:		
Language of comfort: **English**	Communication accommodations: **Blind in left eye; Uses glasses**		

What's Most Important To Me and My Concerns

What is most important to me right now: **My family**

What concerns me most about my health care right now: **pain comes in waves**.

My Care Team (Include active family/caregivers, providers)

Coordinating lead (notify if patient is hospitalized) | Name: **Debbie Smith** | Phone number: **647-555-5550**

Name of team member	Role	Organization	Contact information		Share coordinated care plan
			Primary number	Secondary number	
Dr. Monica Mills	**Family Doctor**	**Maintown FHT**	**647-555-9675**		**yes**
Margaret Franklin	**Wife**	**n/a**	**647-555-5555**		**yes**
Rebecca Franklin	**Daughter**		**647-555-3333**		
William Phillips	**Social Worker**	**Maintown FHT**	**647-555-9675**		**yes**
Nikki Ru	**Pharmacist**	**Maintown Pharmacy**	**647-555-0000**	**Fax 647-555-1111**	**yes**
John Taylor	**PSW**	**Care Helpers Inc.**	**647-555-2222**		**yes**
Dana Tremblay	**Food**	**Meals on Wheels**	**647-555-3333**		**No**

Health Care Consent and Advance Care Planning

Note: Ensure that you've obtained all necessary consents to treatment from the patient or the SDM as required by law.

My health substitute decision maker(s) (SDM) is/are

Name	Relationship	Type of SDM	Contact information	
			Primary phone number	Secondary phone number
Margaret Franklin	**daughter**	**5. Child or parent or Children's Aid Society or other person who is lawfully entitled to make treatment decisions in place of the parent**	**647-555-5555**	**647-555-5556**
I have shared my wishes, values, and beliefs with my future SDM as they relate to my future health care: **yes**				

My Health (Include physical health, mental health and addictions [i.e. smoking], functional issues, assistive devices)	
Issue	Details (onset, considerations)
Bowel cancer	**Pain comes in waves. Pain level 9/10. Have been increasing meds. Ostomy created 2 years ago. Pain comes in waves Retirement home does not manage ostomies – family pays for daily ostomy support.**
GI Bleed & anemia	**Bi-weekly blood transfusions**
Alzheimer's disease	**Difficulty understanding and remembering. Pleasant nature and says 'yes' to all questions.**
Dehydration	**Transferred back and forth +5 times between retirement and hospital with dehydration**
Kidney failure	**Difficulty balancing electrolytes – IV infusion. Hospital gives electrolytes then ships pt to retirement home – at the home the patient rebounds.**
Frailty	**Very weak – unable to sit up in a wheelchair or weight-bear.**
Multiple strokes	**Affected speech and eyes**
Acute Aortic Stenosis leading to Aortic valve replacement -	**2004**
High Blood pressure	**10+ years**

More About Me	
Topics	Details
Income	**CPP & OAS**
Employment	**Trained RN, Retired 30+ years**
Housing	**In hospital now. Was in Retirement home but home unable to provide needed care – transferred back and forth to hospital for electrolyte balancing and transfusions.**
Transportation	**Stretcher required as patient too weak. Sometimes patient is in emergency department for long hours or transferred to retirement home at 4:00 in the morning. "transfers are hard on Mom".**
Food security	**Not eating, needs assistance with sips**
Social network	**3 children (1 out of country), in the past loved to dance.**
Health knowledge	**Healthcare background**
Newcomer to Canada	**n/a**
Legal	**n/a**
Spiritual affiliation	**Not subscribed to a specific faith**
Caregiver issues	**Family add support in the retirement home and attend appointments/hospital visits. One daughter has a young child, both daughters have multiple seniors to support and both work full time**

My Goals and Action Plan				
What I hope to achieve	What we can do to achieve it	Details	Who will be responsible	Date goal identified (YYYY-MMM-DD)
Pain free	**Pain management referral**		**Debbie/Coordinator, Dr. Mills**	**2017-05-31**
Family: Wants less transferring back and forth.	**Look at move to LTC where care levels are higher.**	**Currently on waiting list x 5 years**	**Debbie/Coordinator**	**2017-5-31**
Family: Better fluids/food intake	**Connect with community care Chocking precautions**		**Debbie/Coordinator Dr. Mills**	**2017-5-31**

My Medication Coordination **(Attach current medication list or complete the medication appendix)**	
Most reliable source for medication list (primary prescriber/medication manager/family)**: Maintown Pharmacy**	
Aids I use to take my medications: **Blister Packs**	If someone helps you with medications, who helps you?): **Retirement home PSW**
Challenges I have taking my medications (side effects, are you able to afford all your medications?): **"Mom has difficulty swallowing pills so pills are crushed"**	

My Allergies	No known allergies ☐
What are you allergic or intolerant to?	What happens to you? What are your symptoms?
Penicillin	**Feel sick**
Shellfish	**Anaphylaxis**

Appendices attached: ☒ **Medication List** ☐ **My Health Assessments** ☐ **Most Recent Hospital Visit** ☐ **Most Recent Hospital Visit**

Appendix 1

It is recommended to obtain the most recent medication reconciliation from provider/source where it was most recently completed (e.g. pharmacy, hospital, primary care)

Medication List						
Drugs/medicine	Dose	How often am I taking this medication?	Why am I taking this medication?	Who prescribed the medication?	When did I start taking this medication?	Notes
Percocet	**5/325 mg**	**1-2 tablets as needed space 4 hours apart**	**Pain**	**Family Doctor**	**5 years ago**	
Iron	**300 mgs**	**Once a day (Morning)**	**Anemia**	**Family Doctor**	**10 years ago**	
Lasix	**80 mgs**	**Once a day (Morning)**	**Water pill for high blood pressure**	**Hospital**	**6 mths ago**	
Aricept	**5 mg**	**Once a day (Evenings)**	**Memory**	**Family Doctor**	**5 years ago**	
Pantoprazole	**40 mg**	**Once a day (Morning)**	**Reduce the amount of stomach acid**	**Family Doctor**	**5 years ago**	
Cyanocobalamin Time Released	**500 mg**	**Once a day (Morning)**	**Reduce anemia**	**Family Doctor**	**3 years ago**	
Imodium	**2 mg**	**Twice a day (Morning and Evening)**	**required to help retain water due to ostomy bag**	**Family Doctor**	**4 years ago**	

Appendix 2

My Health Assessments		
Assessment type and name	Date completed	Notes
LACE risk of readmission	**2017-Jan-17**	**Score = 12 – need to look at community support and living location**
Palliative Performance Scale (PPS)	**2017-Feb-2**	**Score 70%, very frail, mainly assistance required for self-care, sips only, there is some confusion when questions asked**
	YYYY-MMM-DD	
	YYYY-MMM-DD	

Appendix 3

My Most Recent Hospital Visit		
Hospital name: **Maintown Hospital**		Visit date: **2017-May-17**
Reason for visit: **Dehydration, electrolyte imbalance**		
Visit description:	☒ Emergency room to home	☐ Emergency room to inpatient unit
Date of discharge: **2017-May 17**	Length of stay:	
Comments: **"Each to trip to hospital my mom is getting weaker"**		

Appendix 4

Palliative Approach to Care		
The person most responsible for my palliative care is: **Margaret Franklin**		
Physical support plan (pain management, shortness of breath, constipation, nausea and vomiting, fatigue, appetite, drowsiness)		
Symptoms	Treatments	Comments
Pain	**Every 4 hours provide around the clock (ATC) dosing with immediate release (IR) opioid and titrate to effect or until side effects become unmanageable**	**See medication list**
Weakness	**Set up picc line and community nursing to support**	
SOB -shortness of breath	**Home oxygen setup in home**	**Oxygen funding for 3 months under palliative diagnosis**
Psychological support plan (emotion, anxiety, depression, autonomy, fear, control, self-esteem)		
Symptoms	Treatments	Comments
Fear	**Listen, comfort, discuss feelings** **Encourage visitors – so not alone** **Roberta loves to dance – play favorite music.**	**Remind Roberta that she is loved and the importance of her life.** **Support visitors and encourage to share stories**
Depression	**Encourage visitors, family to reach out and invite people to visit**	**Family members will take turns visiting**
Social support plan (relationships, family caregiver, volunteers, environment, financial, legal): **Encourage patience—everyone will be at different stages and has different styles.** **Offer to set up extra bed for a family member**		
Spiritual support plan (values, beliefs, practices, rituals):		
Preferred place of death: **Any place that can support care without delays of medication – don't want to be in pain**		
Grief and bereavement support: **Offer Counselling, Social worker from home and community care will visit patient and family to help with planning and discuss finances**		
Other:		