

Service User Care and Risk Management Plan

Name:	
DOB:	Health Care No:
This Care and Risk Management Plan relates to:	
Professional completing the plan:	
Date Completed:	Signatures:
Date Reviewed:	

This Care and Risk Management Plan is a collaborative plan that is underpinned by a range of Multidisciplinary professional assessments. The Plan should be read in conjunction with all the other relevant assessments.

NOK DETAILS:

KEYWORKER DETAILS:

PHYSICAL HEALTH : IF PRESENTS WITH SYMPTONS OF COVID 19 SUCH AS:

-HIGH TEMPERATURE

-A NEW AND CONTINUOUS COUGH –EVEN IF MILD.

THERE IS A NEED FOR STAFF TO FOLLOW PUBLIC HEALTH AGENCY GUIDELINES. (PHA) REGARDING THE USE OF PPE, HAND HYGIENE, SOCIAL DISTANCING, STAYING AT HOME, WHILST PROVIDING CARE TO

STAFF TO ENCOURAGE, REMIND AND SUPPORT SERVICE USERS TO ENGAGE IN GOOD EFFECTIVE HAND HYGIENE.

STAFF TO SUPPORT AND ENCOURAGE WHERE POSSIBLE, SOCIAL DISTANCING (2 METRES APART).

SHOULD ANYONE PRESENT WITH SYMPTONS OF COVID 19 STAFF SHOULD CONTACT 111 FOR INFORMATION / ADVICE AND FOLLOW GUIDANCE PROVIDED.

DO NOT ATTEND GP, HOSPITAL OR PHARMACY.

CALLING THE GP IS ONLY NECESSARY IF A CLIENT HAS:

-AN EXISTING HEALTH CONDITION

-PROBLEMS WITH THEIR IMMUNE SYSTEM

-VERY SERIOUS SYMPTONS.

IF IT IS A MEDICAL EMERGENCY AND AN AMBULANCE IS REQUIRED STAFF SHOULD DIAL 999 AND INFORM THE OPERATOR OF CLIENT'S SYMPTONS.

Professionals who contribute to Care and Risk Management Plan

Name	Designation	Assessment Carried Out Date	Report Provided

Care and Risk Management Plan

Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need: 1 - <u>Physical Health</u> Risk:			<u>Risk Rating:</u>
Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need: 2 - <u>Mental Health & Emotional Well-being</u> Risk:			<u>Risk Rating:</u>
Identified Needs/ Risks (N) None (move to next domain)	Strengths	What needs to happen to meet need / risk	Desired Outcome

(Y) Please expand.		(By whom)	
<p>Need: 3 - <u>Level of awareness & decision making skills</u></p> <p>Risk:</p>			<p><u>Risk Rating:</u></p>
Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
<p>Need: 4 - <u>Medicines management. Attach medications plan as appropriate</u></p> <p>Risk:</p>			<p><u>Risk Rating:</u></p>

Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need: 5 - <u>Communication and sensory functioning</u> Risk:			<u>Risk Rating:</u>
Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need: 6- <u>Walking and movement;</u> <u>Attach safe systems plan as appropriate</u> Risk:			<u>Risk Rating:</u>

Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need 7- <u>Personal care and daily tasks</u> Risk:			Risk Rating:
Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need 8- <u>Living arrangements and accommodation</u> Risk:			Risk Rating:
Identified Needs/ Risks (N) None (move to next domain) (Y) Please expand.	Strengths	What needs to happen to meet need / risk (By whom)	Desired Outcome
Need			

Signed: _____	Service User	Date: _____
_____	Carer/ Advocate	Date: _____
_____	Case Manager	Date: _____
_____	AHP/ Other named party	Date: _____

Review Date: _____

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_____	Carer/ Advocate	Date: _____
_____	Case Manager	Date: _____
_____	AHP/ Other named party	Date: _____

Note: on completion of the Care and Risk management Plan, please upload / attach onto PARIS and please forward copy to the Service User and Carer / Family