**Extra Care Pathway**

|  |  |
| --- | --- |
| **Home / Unit**  |  |
| **Name** |  |
| **Room Number** |  |
| **Date of Birth** |  |

**Contact details:**

|  |  |
| --- | --- |
| **Home Manager** |  |
| **GP** |  |
| **District Nurse** |  |
| **Next of Kin** |  |
| **Other …………** |  |

**Allergies:**

|  |
| --- |
|  |

**Index:**

|  |  |
| --- | --- |
| **Item**  | **Implemented Y/N** |
| Acute Care Plan |  |
| Professionals Input Record |  |
| Carers Input Record |  |
| Chef/Cook Input Record |  |
| Fluid Chart  |  |
| Food Chart |  |
| Bowel Chart |  |
| TPS/OBS (can be RESTORE2 chart)  |  |
| Behaviour Monitoring  |  |
| Risk Assessments (Moving & handling/Pressure care) |  |
| Body Map  |  |
| Bedrails Risk Assessment  |  |
| Specific Care Assessments  |  |

Date Started Date Completed

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| --- |
| **Aim of the ECP:** |
| The Extra Care Pathway (ECP) will support clear communication, a joint way of working and continuity of care. The pathway gives relatives and professional piece of mind that a person is receiving an enhanced level of care and support when it is needed.  |
| **What will prompt an ECP care plan?** |
| * Chest infection
* UTI
* Recurring falls
* Discharge from hospital (72 hours monitoring)
* Sudden change in behaviour requiring special observation
* TIA
* Acute infection
* Any other short-term condition as agreed by the Senior team
 |
| **Guidance for Implementation:** |
| 1. Individual is identified as requiring an ECP Acute Care Plan
2. In the daily notes in the current care plan state ‘**individual transferred to ECP care plan’** – the start date is then written on the front of the ECP.
3. This care plan and notes will be used for the duration of the acute illness to a maximum of two weeks.
4. The care plan is then completed by every person attending to the individual (GP, DN and care staff).
5. At the end of every day the care plan is signed off by the home manager (or designated person) and the cook/chef on duty. Any outstanding actions should be identified and actioned as soon as possible.
6. When the ECP is no longer required, the cancellation date is place on the front sheet and the original care plan will then go back into use. **Please ensure the original care plan is up to date with any changes.**
 |

**SCORE TRACKER OVERVIEW**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **News Score (clinical risk)** | **Pain score** | **Braden Score Low/Med****High/Severe** | **Pressure Sore Grade** | **Action Taken** | **Result** | **Role** | **Signed** |
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| --- | --- | --- | --- | --- |
| **Care Plan No:** | **Acute Care Plan Actions:** | **Care Plan Goal:** | **Level of Need: please circle** | **No of Staff** |
|  |  |  | Red | Amber | Green |  |
| **2.** |  |  | Red | Amber | Green |  |
| **3.** |  |  | Red | Amber | Green |  |
| **4.** |  |  | Red | Amber | Green |  |
| **5.** |  |  | Red | Amber | Green |  |
| **6.** |  |  | Red | Amber | Green |  |
| **7.** |  |  | Red | Amber | Green |  |
| **8.** |  |  | Red | Amber | Green |  |

**Professional Input Record:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Designation** | **Notes** | **Name & Signed** |
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**Carers Input Record:**

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| **Date** | **Designation** | **Notes** | **Name & Signed** |
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**Cook/Chef Input Record:**

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| --- | --- | --- | --- |
| **Date** | **Designation** | **Notes** | **Name & Signed** |
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**Manager Daily Review Record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Update/Review** | **Actions Identified** | **Name & Signed** |
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**Fluid Intake Record (24 hour) Recommended Intake…………/24 hours**

|  |  |  |  |
| --- | --- | --- | --- |
| **Time** | **Description of Drink** | **Fluid consumed orally**  | **Fluid consumed method (PEG, supplements, medication)** |
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|  |  | **TOTAL:**  |  |

|  |  |
| --- | --- |
| **Signs & Symptoms of Dehydration:** | **Notes** |
| Dry furrowed tongue |  |
| Rapid pulse |  |
| Concentrated urine |  |
| Decreased output of urine |  |
| Sunken eyes |  |
| Muscle weakness  |  |

|  |
| --- |
| **Give a reason why fluid intake has not been achieved:****Actions taken:**Name: Signature: Date: |

**Food Intake Record**

|  |  |
| --- | --- |
| **Date of commencement on Food Intake Record** |  |
| **Rationale for commencing** |  |
| **Start weight**  |  |
| **Name/signature of person commencing chart** |  |

|  |  |  |
| --- | --- | --- |
|  | **Amount consumed:** | **Omission or refusal:**  |
| **Time** |  |  |
| **Description & Amount**  |  |  |
| **Time** |  |  |
| **Description & Amount** |  |  |
| **Time** |  |  |
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| **Description & Amount**  |  |  |
| **Time** |  |  |
| **Description & Amount**  |  |  |

|  |
| --- |
| **Guidance** |
| **Amount consumed**: how many heaped or level teaspoons? Size of spoon? How much food?**Omission or refusal**: give reasons if client is declining or omitting food, snacks and supplements |

|  |  |
| --- | --- |
| **Review of intake**  |  |
| **Action plan**  |  |
| **Is the care plan up to date**  |  |
| **Name/Signature**  |  |

**Bowel Chart (month)**

**Key:** Small **S**  Medium **M**  Large **L**

**(Assess size of each bowel movement)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Bowel MovementPlease **√ + KEY** DAY | Bristol Stool - Type | Staff initial | Bowel MovementPlease **√ + KEY** NIGHT | Bristol Stool - Type | Staff initial |  |
| 1 |  | Type: |  |  | Type: |  |
| 2 |  | Type: |  |  | Type: |  |
| 3 |  | Type: |  |  | Type: |  |
| 4 |  | Type: |  |  | Type: |  |
| 5 |  | Type: |  |  | Type: |  |
| 6 |  | Type: |  |  | Type: |  |
| 7 |  | Type: |  |  | Type: |  |
| 8 |  | Type: |  |  | Type: |  |
| 9 |  | Type: |  |  | Type: |  |
| 10 |  | Type: |  |  | Type: |  |
| 11 |  | Type: |  |  | Type: |  |
| 12 |  | Type: |  |  | Type: |  |
| 13 |  | Type: |  |  | Type: |  |
| 14 |  | Type: |  |  | Type: |  |
| 15 |  | Type: |  |  | Type: |  |
| 16 |  | Type: |  |  | Type: |  |
| 17 |  | Type: |  |  | Type: |  |
| 18 |  | Type: |  |  | Type: |  |
| 19 |  | Type: |  |  | Type: |  |
| 20 |  | Type: |  |  | Type: |  |
| 21 |  | Type: |  |  | Type: |  |
| 22 |  | Type: |  |  | Type: |  |
| 23 |  | Type: |  |  | Type: |  |
| 24 |  | Type: |  |  | Type: |  |
| 25 |  | Type: |  |  | Type: |  |
| 26 |  | Type: |  |  | Type: |  |
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| 28 |  | Type: |  |  | Type: |  |
| 29 |  | Type: |  |  | Type: |  |
| 30 |  | Type: |  |  | Type: |  |
| 31 |  | Type: |  |  | Type: |  |

**Behaviour Monitoring**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date & Time** | **Description** | **Name & Signature**  |
| **Behaviour**  |  |  |  |
| **Identified Trigger** |  |  |
| **Action** |  |  |
| **Outcome**  |  |  |
|  |  |  |  |
| **Behaviour**  |  |  |  |
| **Identified Trigger** |  |  |
| **Action** |  |  |
| **Outcome** |  |  |
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| **Behaviour** |  |  |  |
| **Identified Trigger** |  |  |
| **Action** |  |  |
| **Outcome**  |  |  |
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| **Behaviour** |  |  |  |
| **Identified Trigger** |  |  |
| **Action** |  |  |
| **Outcome**  |  |  |
|  |  |  |  |
| **Behaviour**  |  |  |  |
| **Identified Trigger** |  |  |
| **Action** |  |  |
| **Outcome**  |  |  |

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| --- |
| **Guidance:****Behaviour** – before, during, afterwards **Identified Trigger** – for example, approach, tone of voice, environment**Action** – De-escalation techniques, diversion, medication, conflict resolution**Outcome** – Care plan documentation or review, risk management plan development, incident form.  |

**Risk Assessments – Moving & Handling**

| **Date** |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Characteristics** | **Score** | **Score** | **Score** | **Score** | **Score** | **Score** |
| **Mobility:**Able to stand and balance with:1 person and/or equipment2 people and/or equipmentUnable to stand | 137 |  |  |  |  |  |  |
| **Mobility in Bed:**Unable to use right armUnable to use left armUnable to use right legUnable to use left leg | 3333 |  |  |  |  |  |  |
| **Mental State:**AnxiousConfused/disorientatedDrowsy/semi-consciousUnconsciousUnable/unwilling to follow instruction | 12345 |  |  |  |  |  |  |
| **Skin Condition:**Bruising/discolorationOedematousDry/cracked/very thinSores/wounds on or near handling points | 1225 |  |  |  |  |  |  |
| **Pain:**General mild discomfortMild pain on movementSevere pain on movementSevere general painRequires pain killers before movement | 11233 |  |  |  |  |  |  |
| **Continence:**Incontinent of urineIncontinent of faecesIncontinent of body fluids | 111 |  |  |  |  |  |  |
| **Height:**Below 5’ 4”5’ 4” – 5’ 8”5’ 8” – 6’Above 6’ | 1234 |  |  |  |  |  |  |
| **Weight:**Under 55kg (8.5st)56kg – 70kg (8.5 – 11st)71kg – 90kg (11-14st)91kg + (14st+) | 1234 |  |  |  |  |  |  |
| **Special Risk:**DementiaVertigo/giddinessFalls in last 4 weeks  | 224 |  |  |  |  |  |  |
| **Invasive Equipment:**Syringe driverCatheter /colostomyOxygen | 111 |  |  |  |  |  |  |
| **Working Space:**Good/clearCluttered/able to clearRestricted/unable to clear | 123 |  |  |  |  |  |  |
| **Bed:**Fixed heightDifficult to move | 22 |  |  |  |  |  |  |
| **Total Score** |  |  |  |  |  |  |  |
| **Assessors Signature** |  |  |  |  |  |  |  |

**Score:**

**20 + High Risk**

**11-19 Medium Risk**

**0 – 10 Low Risk**

**Pressure Care Risk Assessment**

|  |
| --- |
| **BRADEN SCALE – PRESSURE ULCER RISK ASSESSMENT** |

Undertake and document risk assessment within 6 hours of admission. Reassess if there is a change in individual’s condition and repeat regularly according to local policy

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Sensory Perception** |  | **Moisture** |  | **Activity** |  | **Mobility** |  | **Nutrition** |  | **Friction and Shear** |  |
| **No Impairment** | **4** | **Rarely Moist** | **4** | **Walks Frequently** | **4** | **No Limitations** | **4** | **Excellent** | **4** |  |  |
| **Slightly Limited** | **3** | **Occasionally Moist** | **3** | **Walks Occasionally**  | **3** | **Slightly Limited** | **3** | **Adequate** | **3** | **No Apparent Problem** | **3** |
| **Very Limited** | **2** | **Very Moist** | **2** | **Chair Bound** | **2** | **Very Limited** | **2** | **Probably Inadequate** | **2** | **Potential Problem** | **2** |
| **Completely Limited** | **1** | **Constantly Moist**  | **1** | **Bedbound**  | **1** | **Completely Immobile**  | **1** | **Very Poor**  | **1** | **Problem**  | **1** |

|  |
| --- |
| Score \_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **A SCORE OF 16 OR LESS INDICATES THAT A PERSON IS AT RISK OF PRESSURE ULCER DEVELOPMENT** |
| Is there evidence of skin damage from pressure during this assessment? YES/NO/NOT EXAMINED/REFUSED EXAMINATIONIf YES, please give details of grade and site of damage  |

**RE-ASSESSMENTS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  DATE |  |  |  |  |  |  |
|  |  TIME |  |  |  |  |  |  |
|  | **Sensory Perception** |  |  |  |  |  |  |
| 4321 | No impairmentSlightly LimitedVery LimitedCompletely Limited |  |  |  |  |  |  |
|  | **Moisture** |  |  |  |  |  |  |
| 4321 | Rarely MoistOccasionally MoistVery MoistConstantly Moist |  |  |  |  |  |  |
|  | **Activity**  |  |  |  |  |  |  |
| 4321 | Walks FrequentlyWalks OccasionallyChair BoundBedbound |  |  |  |  |  |  |
|  | **Mobility**  |  |  |  |  |  |  |
| 4321 | No LimitationsSlightly LimitedVery LimitedCompletely Immobile  |  |  |  |  |  |  |
|  | Nutrition  |  |  |  |  |  |  |
| 4321 | ExcellentAdequateProbably InadequateVery Poor |  |  |  |  |  |  |
|  | **Friction and Shear** |  |  |  |  |  |  |
| 321 | No Apparent ProblemPotential ProblemProblem  |  |  |  |  |  |  |
|  | Score: Low risk – 15-18— Braden monthlyModerate risk – 13-14 Braden weekly High risk – 10-12 Braden daily Severe risk – Total score 9 Skin bundle  |  |  |  |  |  |  |
|  | Evidence of pressure damage?Yes No Refused  |  |  |  |  |  |  |
|  | If Yes, grade and site? |  |  |  |  |  |  |
|  | NAME:SIGNATURE: |  |  |  |  |  |  |

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| **Braden Risk Assessment Guide**Individuals with a total score of 16 or less are considered at riskLow risk – 15-18 Moderate risk – 13-14 High risk – 10-12 Severe risk – Total score 9  |
| **Sensory Perception** Ability to respond meaningfullyto pressure related discomfort | **Moisture** -Degree to which skin is exposed to moisture | **Activity** -Degree of physical activity | **Mobility** - Ability to change and control body position | **Nutrition** -Usual food intake pattern | **Friction and Shear** |
| 1. Completely Limited.Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface. | 1. Constantly Moist.Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient/ client is moved or turned. | 1. Bedfast.Confined to bed. | 1. Completely Immobile. Does not make even slight changes in body or extremity position without assistance. | 1. Very Poor.Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NBM and/or maintained on clear liquids or IV’s for more than 5 days. | 1. Problem.Requires moderate to maximum assistance in moving. |
| 2. Very Limited.Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment that limits the ability to feel pain or discomfort over ½ of body. | 2. Very Moist.Skin is often, but not always, moist. Linen must be changed at least once a shift. | 2. ChairfastAbility to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. | 2. Very LimitedMakes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. | 2. Probably Inadequate.Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding. | 2. Potential Problem.Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down. |
| 3. Slightly LimitedResponds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment that limits ability to feel pain or discomfort in 1 or 2 extremities. | 3. Occasionally Moist.Skin is occasionally moist, requiring an extra linen change approximately once a day. | 3. Walks OccasionallyWalks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 3. Slightly LimitedMakes frequent though slight changes in body or extremity position independently. | 3. Adequate.Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs. | 3. No Apparent Problem.Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. |
| 4. No Impairment.Responds to verbal commands. Has no sensory deficit that would limit ability to feel or voice pain or discomfort. | 4. Rarely Moist.Skin is usually dry. Linen only requires changing at routine intervals. | 4. Walks FrequentlyWalks outside the room at least twice a day and inside the room every 2 hours during waking hours. | 4. No LimitationsMakes major and frequent changes in position without assistance. | 4. Excellent.Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. |  |

**Body Map**

|  |
| --- |
| **Female**  |
|  |
| **Male** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date**  | **Action Taken** | **Review/Result** | **Signed** |
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**Bedrail Assessment**

|  |  |
| --- | --- |
| **Date:** | **Assessor:** |
| **Risk Balance Questions** | Yes | No |
| Is the client likely to fall out of bed? |  |  |
| Is the client likely to be injured in a fall from bed? |  |  |
| Will the client be anxious if bedrails are not in place? |  |  |
| Would the bedrails stop the client from being independent? |  |  |
| Is the client likely to climb over the bedrails? |  |  |
| Could the client injure themselves on the bedrails? |  |  |
| Will using bedrails cause the client distress? |  |  |
| Is the bedrail suitable for the bed and mattress? |  |  |
| Is there a risk that any part of the client’s body (e.g. neck, arms, legs, chest) could become trapped between the bedrails bars or other gaps created by bed, rail, mattress and headboard combination? |  |  |
| **Risk Matrix Tool** |
| Mental State | Client is confused and disorientated | Use bedrails with care | Bedrails NOT recommended | Bedrails NOT recommended |
| Client is drowsy | Bedrails recommended | Use bedrails with care | Bedrails NOT recommended |
| Client is orientated and alert | Bedrails recommended | Bedrails recommended | Bedrails NOT recommended |
| Client is unconscious | Bedrails recommended | Not applicable | Not applicable |
|  |  | Client is immobile (never leaves bed) or is hoist dependant | Client requires physical help with mobility | Client mobilises without help from staff |
|  | Mobility |
| **Outcome of assessment** | **Rational for decision** |
| (Circle as appropriate)Bedrails used Bedrails not used | All decisions made should be documented in the care plan and/or risk management plan depending on the circumstances and risks presented. If there are changes in the client care this decision should be reviewed as appropriate. |

**Personalised Care Requirements;**

**MANAGEMENT PLAN**

**Name:**

**Room:**

|  |  |  |
| --- | --- | --- |
|  | MANAGEMENT PLANArea of care/support: |  |
| Date | Things you need to know to support me, keep me safe and minimize risk  | Signed |
| Date | What staff need to do if things go wrong – Who to contact etc | Signed |

**Personalised Care Requirements;**

**MANAGEMENT PLAN**

**Name:**

**Room:**

|  |  |  |
| --- | --- | --- |
|  | MANAGEMENT PLANArea of care/support: |  |
| Date | Things you need to know to support me, keep me safe and minimize risk  | Signed |
| Date | What staff need to do if things go wrong – Who to contact etc | Signed |

**Personalised Care Requirements;**

**MANAGEMENT PLAN**

**Name:**

**Room:**

|  |  |  |
| --- | --- | --- |
|  | MANAGEMENT PLANArea of care/support: |  |
| Date | Things you need to know to support me, keep me safe and minimize risk  | Signed |
| Date | What staff need to do if things go wrong– Who to contact etc | Signed |

**Personalised Care Requirements;**

**MANAGEMENT PLAN**

**Name:**

**Room:**

|  |  |  |
| --- | --- | --- |
|  | MANAGEMENT PLANArea of care/support: |  |
| Date | Things you need to know to support me, keep me safe and minimize risk  | Signed |
| Date | What staff need to do if things go wrong– Who to contact etc | Signed |