Planning care at home check list

Use the key areas of assessment below to consider what support is already in place, and what else might be needed when planning care for clients with advancing ill health. Review this checklist from time to time, particularly if and when a clients health deteriorates further, as needs change.

Place of care issues	No Need	Need	What's needed / Who can help
Complex health or behavioural needs *(e.g. struggling with multiple health needs – case review needed)*			
Building access – stairs/outside areas, mobility, out-of-hours access *(e.g. ground floor room needed as client struggling with mobility/shared bathroom)*			
Operational and procedural policies *(e.g. storage of medicines, lone working – review of policies needed)*			
Medical, nursing and personal care provision *(e.g. managing difficult symptoms – referral to palliative care needed)*			
Safeguarding issues *(e.g. vulnerability concerns, exploitation, self-neglect – additional monitoring needed)*			
Lack of appropriate places of care – particularly in last months of life *(e.g. limited or no availability – 24hr manned project or additional night care needed)*			
Impact of illness on other clients or staff *(e.g. some staff or clients struggling to manage – additional emotional support needed)*			

Your role	No need	Need	What's needed / Who can help
Expectations of yourself, of the project, of external services *(e.g. expectation on you to provide bulk of care - multi-agency meeting needed to share care)*			
Limitations of your role *(e.g. non-clinical role, personal care not in your remit – more support from healthcare professionals needed)*			

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Multi-agency response	No need	Need	What's needed / Who can help
Appropriate levels of support for client in place *(e.g. limited support - palliative care or social services input needed).*			
Appropriate level of support for you and the team *(e.g. additional management support or reflective practice needed)*			
Meeting the criteria for additional input (*e.g. difficulties managing symptoms and personal care – referral for continuing healthcare funding (CHC) needed*			
Communication/information sharing *(e.g. poor communication between professionals – more frequent meetings needed)*			
Impact on client	**No need**	**Need**	**What's needed / Who can help**
Client's understanding about their health – level of insight? (*e.g. wishes not known – conversation needed, shared or 1-1)*			
Coping strategies – clients experience of managing their illness (*e.g. poor coping strategies – encouragement around helpful strategies needed?*			
Engaging with other services – how open are they with others? *(e.g. poor engagement – multi-agency meeting needed to explore further)*			
Significant others – helpful or unhelpful support for the client? *(see the Eco-map in section 2 of the main toolkit)*			