# Appendix 3 – needs portrayal template

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## Cover page

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| Integrated care board |  |
| Individual’s name |  |
| NHS number |  |

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| Date  of birth: |  | Date of death (if applicable): | |  | Gender: |  | | | Age: |  | Ethnicity: |  |
| Applicant’s name: | |  | | | | | Start date of periods under  consideration: | | |  | | |
| Relationship to the individual: | |  | | | | | End date of periods under  consideration: | | |  | | |
| Address of individual: at time of period under consideration (please add all addresses) | | | | | | | | | | GP details | | |
|  | | | | | | | | | |  | | |
| Name of person preparing the report: | | |  | | | | | Signature: | |  | | |
| Professional qualifications of person preparing the report: | | |  | | | | | Date: | |  | | |

### Summary of evidence used

|  | Please tick if used to inform this document  (If evidence is not available, please state the reason - for example, care home closed; notes destroyed) |
| --- | --- |
| Care home records |  |
| Hospital records |  |
| GP records |  |
| Social care services records and/or assessments |  |
| District nursing records and/or community records |  |
| Mental health records |  |
| NHS continuing healthcare (CHC) and/or NHS-funded nursing care (FNC) assessments |  |
| Other specialist records (for example, dietician, physiotherapy, speech and language therapy, tissue viability)  Please specify. |  |

## Guidance notes for completing this document

This document is intended to be an objective record of an individual’s health and social care needs during a specified period.   
For more guidance on how to complete this needs portrayal please refer to the guidance notes below.

It is to be completed by an individuals with the appropriate skills or qualifications to pick out the relevant information as required. The needs should be drawn from all the available sources of evidence, including that from the applicant.

As far as possible, your findings should be in chronological order.

Remember to reference the source of information on the form (for example, care home records) and to identify the point in the records. This will make it easier to refer to if necessary.

Where information is not available or there is no supporting evidence, state this clearly.

## Medical history

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| Medical history in date order (High-level overview) If the individual is deceased, include cause of death if known | |  |
| Date | Findings | Source of information |
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| Findings | Source of information  For example, care home records, GP records |
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## Summary of individual's situation

Summary pen portrait of the individual’s situation, relevant history (particularly clinical history), including clinical summary and identified significant risks. Please include social history, capacity and safeguarding.

## Chronology of key event

Events leading up to this needs portrayal including:

* individual's pathway
* hospital admissions and dates
* relevant assessments and dates
* previous NHS CHC considerations if applicable and dates

| Date | Findings | Source of information |
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## Care domains

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| Breathing:  This domain includes but is not limited to: | | | | | | |
| breathlessness due to respiratory, cardiac, other condition  Smoking history | | Disease history  Exacerbation or COPD  medications and the need for oxygen, inhalers, nebulisers | | Specialist intervention and/or equipment needs input  Airway clearance techniques, BiPAP CPAP, tracheostomy, ventilation | | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | | | Source of information  For example, care home records, GP records |
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| Nutrition – food and drink:  This domain includes but is not limited to: | | | | | | |
| Nutritional status including weight, BMI, food and fluid type – Intervention times  Assessment tools | | | Aids and adaptations  Alternative feeding methods (please specify)  likes or dislikes  Can they eat and drink independently or require assistance? If requires assistance how long does it take? | | Problems, for example swallow, aspiration  Specialist intervention, needs input, SALT | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | | | Source of information  For example, care home records, GP records |
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| Continence:  This domain includes but is not limited to: | | | | |
| Level of continence  Level of dependence | | Aids and equipment required, such as stoma, catheter – are they problematic?  Recurrent UTIs | Specialist interventions and/or needs input  Frequency of any required monitoring | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| Skin including tissue viability:  This domain includes but is not limited to: | | | | |
| Actual and potential problems  Risk assessment, such as Waterlow  Details of wounds and treatments, Pressure sore gradings, responding to treatment? | | Skin conditions and treatment required  Aids and equipment needs  Related medical conditions | Positioning, turning  Specialist intervention/needs input, TVN, dermatology  Frequency of monitoring | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| Mobility:  This domain includes but is not limited to: | | | | |
| Level of independence, dependence  Level of supervision/assistance –number of staff required | | Aids and equipment needed  Moving and handling assessment  Maintaining a safe environment | Risk assessments, such as falls  Specialist intervention/needs input/Physiotherapist/OT  Contractures/spasms | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| |  |  |  | | --- | --- | --- | | Communication:  This domain includes but is not limited to: | | | | Verbal and non-verbal abilities/fluctuations  Comprehension  Can they understand instructions? | Can they make their needs known verbally/non-verbally? Or can they be anticipated?  Aids used/needed  Specialist input  Sensory deficits | Extreme frustration associated with communication difficulties  Hazards – insights into, are they able to request help?  SALT assessment | | | | |
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| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | Source of information  For example, care home records, GP records |
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| Psychological and Emotional Needs:  This domain includes but is not limited to: | | | | |
| Mood Disturbance and anxiety symptoms – predictable/unpredictable | | Withdrawn? Do they participate in activities of Daily Living and care planning (or is this due to cognitive impairment)?  Medication required | Do they respond to prompts and reassurance?  Specialist intervention/needs input | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| Cognition:  This domain includes but is not limited to: | | | | |
| Cognitive function – Memory/decisions and choices  Awareness of needs and basic risks  Insight into impairment? | | Orientation – time/place/person  Confusion  Delusions/preoccupations/paranoia/ hallucinations | Specialist intervention  Assessment tools/Mini Mental state examination undertaken | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| |  |  |  | | --- | --- | --- | | Behaviour:  Challenging behaviour in this domain includes but is not limited to: | | | | Persistent noisiness  Persistent restlessness  Inappropriate interference with others  Inappropriate sexual behaviour  Inappropriate urination | Faecal Smearing  Severe disinhibition  Wandering  ­Physical violence  Threatening violence  Verbal abuse | Extreme frustration associated with communication difficulties  Resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance)  Risk to self and/or others  Identified high risk of suicide  What is the frequency of the behaviour?  Are there known triggers?  How is the behaviour managed?  Are skilled interventions required?  Is the person on medication to control behaviour? | | | | | |
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| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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### Medication – reference only

| Name of drug, /used for | Dose | Frequency | Route | Compliance | Frequency of review |
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| Medication/Symptom control:  This domain includes but is not limited to: | | | | |
| Administration/compliance  Aids & equipment  Qualified input e.g. PRN medication  Monitoring of medication in relation to fluctuating physical/mental conditions  Are there strategies in place to aid compliance with medication? E.g. covert medication regime? And if so, has this been formally authorised? | | Level of dependency, educational needs, physical abilities  Ability of understanding  Allergies  Levels and location of pain and effectiveness of pain control measures | Pain assessment tools/assessment  Equipment  Compliance  Specialist intervention needs input e.g. Macmillan | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| Altered States of Consciousness:  This domain includes but is not limited to: | | | | |
| Describe the type of ASC – e.g. seizures, hypotension, hypoglycaemia, Stroke, TIA  Describe frequency, length and severity of episodes  Describe resultant risk of harm | | Are they predictable or unpredictable/are there triggers? | Outline intervention required – e.g. buccal midazolam for seizures  Is any emergency input required and if so what and how often? | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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| Other significant care needs:  This domain includes but is not limited to: | | | | |
| Actual sleep pattern  Identifying any sleep deficits | | Need for intervention, such as continence needs, safety issues, moving and handling, feeding  Mental function | Equipment needs.  Medication issue needs | |
| Date of record | Findings (including frequency, intensity, involvement of other health care professionals, number of people required – list events in date order) | | | Source of information  For example, care home records, GP records |
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## Applicant's comments on the needs portrayal

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| Signature of the applicant: | \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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