Lifetime Care Plan Report

Legal & General

A General information

Resident's name

Date of birth D D M M Y Y Y Y

Legal & General Reference no:

1) What was the date of permanent admission for the resident? M M Y Y Y Y

2) What is the type of care required? ☐ Nursing care ☐ No nursing care ☐ PWD (formerly EMI)

3) Marital status of resident? ☐ Unmarried ☐ Married ☐ Divorced/ separated ☐ Widow/ widower ☐ Unknown

4) Has the resident suffered the loss of a close relative or partner in the last 12 months? ☐ Yes ☐ No ☐ Unknown

If Yes, relationship to resident

5) Is the resident:

☐ Socially active member of the community, engages with other residents?

☐ Mildly interactive with moderate social engagement?

☐ Withdrawn, showing little interest in social engagement?

☐ Severely withdrawn and isolated?

6) Does the resident have regular visits from family/friends? ☐ No ☐ Rarely ☐ Often

7) Does the resident look after their own financial affairs? ☐ Yes ☐ No ☐ Unknown

If Yes or No, please give details

8) Does the resident administer their own medication? ☐ Yes ☐ No ☐ Unknown

If Yes or No, please give details

9) Does the resident possess the capacity and understanding to make detailed financial decisions? ☐ Yes ☐ No ☐ Unknown

If Yes or No, please give details

B Diseases and impairments

This section relates to the resident's medical history. Please complete these questions based on your knowledge of the resident, referring to medical notes held at your facility where possible.

10) Cancer ☐ Yes ☐ No

If Yes, please confirm the following if known:

Type/site/stage of cancer

Date of diagnosis M M Y Y Y Y

Prognosis ☐ Is the cancer in remission? ☐ Is the resident receiving palliative care? ☐ Don't know

11) Heart/ cardiovascular disease ☐ Yes ☐ No

If Yes, type of heart condition and date of diagnosis (Please list all if resident has suffered multiple events)

☐ MI M M Y Y ☐ Angina M M Y Y

☐ Heart failure M M Y Y ☐ Cardiomyopathy M M Y Y

☐ Atrial fibrillation M M Y Y

12) Stroke ☐ Yes ☐ No

If Yes, what type of stroke did the resident suffer from and what was the date of diagnosis? (Please list all if resident has suffered multiple events)

☐ CVA M M Y Y ☐ TIA M M Y Y

☐ SAH M M Y Y

What is the severity of symptoms? ☐ Minimal impact on ADLs ☐ Moderate impact on ADLs ☐ Significant impact on ADLs

13) Diabetes ☐ Yes ☐ No

Type of diabetes? ☐ Type 1 ☐ Type 2

Date of diagnosis M M Y Y Y Y

Does the resident suffer with any of the following diabetic complications? ☐ Retinopathy ☐ Neuropathy ☐ Kidney disease ☐ Peripheral vascular disease

14) Pneumonia ☐ Yes ☐ No

If Yes, how many episodes has your resident had in the last 12 months?

15) Chest infections ☐ Yes ☐ No

If Yes, how many episodes has your resident had in the last 12 months?

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B Diseases and impairments continued

16) Chronic respiratory disease ☐ Yes ☐ No

If Yes, type of disease ☐ COPD ☐ Emphysema ☐ Bronchiectasis

Date of diagnosis M M Y Y Y Y

Nature of symptoms? ☐ Mild, infrequent symptoms? ☐ Moderate regular symptoms? ☐ Severe continuous symptoms?

17) Joint disorders ☐ Yes ☐ No

If Yes, type of joint disorder ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Osteoporosis ☐ Joint replacement

If Yes, joints affected

Severity of symptoms ☐ Mild ☐ Moderate ☐ Severe

18) Has the resident had pressure ulcers in the last 12 months? ☐ Yes ☐ No

Are they still present? ☐ Yes ☐ No

19) Parkinson's Disease ☐ Yes ☐ No

If Yes, date of diagnosis (if known) M M Y Y Y Y

If Yes: What are the severity of symptoms? ☐ Localised tremor ☐ Global tremor ☐ Poor mobility with falls

20) Depression

Is there any ongoing depression, requiring treatment? ☐ Yes ☐ No

If Yes, date of diagnosis M M Y Y Y Y

Severity of any ongoing symptoms ☐ Mild ☐ Moderate ☐ Severe

21) Does the resident have a history of falls in the last 6 months? ☐ Yes ☐ No

If Yes, how many?

Did the resident suffer any fractures? ☐ Yes ☐ No

If Yes, please give details

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B Diseases and impairments continued

22) Does the resident suffer from any of the following:

Chronic pain?

☐ Yes ☐ No

If Yes ☐ Sometimes ☐ Frequently ☐ Always

Shortness of breath?

☐ Yes ☐ No

If Yes ☐ Sometimes ☐ Frequently ☐ Always

Chest pain?

☐ Yes ☐ No

If Yes ☐ Sometimes ☐ Frequently ☐ Always

23) Do you have the resident's latest height and weight details?

Is the resident able to maintain their build? ☐ Yes ☐ No

If No, please give details

24) Please provide details of any other impairment or medical condition that the resident suffers from that has not been captured above

25) Please list all regular treatment the resident is taking, including dose if available

C Dementia and cognition

This section relates to the resident's cognitive function. Please complete as accurately as possible based on the resident's current level of cognition.

26) Has the resident been formally diagnosed with dementia? ☐ Yes ☐ No

If Yes, what type of dementia does your resident suffer from? ☐ Alzheimer's ☐ Vascular ☐ Lewy Body ☐ Other ☐ Unknown

Date of diagnosis M M Y Y Y Y

Latest MMSE score (out of 30) ___/30

Date of test M M Y Y Y Y

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C Dementia and cognition continued

Previous MMSE score ___/30

Date of test M M Y Y Y Y

Result of any other cognition assessment (Ace III, Mini-Cog)

What symptoms does the resident exhibit?

☐ Memory loss ☐ Confusion ☐ Inappropriate behaviour ☐ Failure to recognise family or friends

27) How would you assess the resident's cognitive function in relation to the following:

Orientation in time and place?
☐ Normal ☐ Slightly limited ☐ Limited ☐ Poor

Communication?
☐ Normal ☐ Slightly limited ☐ Limited ☐ Poor

Comprehension/understanding?
☐ Normal ☐ Slightly limited ☐ Limited ☐ Poor

Memory?
☐ Normal ☐ Slightly limited ☐ Limited ☐ Poor

28) How much has the patient's cognitive function deteriorated in the last six months?

☐ Little or none ☐ Moderately ☐ Significantly ☐ Unknown

D Activities of daily living (ADL)

The following set of questions relate to the resident's ability to perform activities of daily living. Your answers should reflect what the resident is capable of on an average day (not a good or bad day); a physical examination is not required.

Guidance note:
Never – resident never needs assistance to perform this ADL
Sometimes – resident sometimes requires assistance to perform this ADL but is usually independent
Most of the time – resident requires assistance most of the time to perform this ADL
Always – resident always requires assistance to perform this ADL

29) **Mobility** – Does the resident require any of the following to move from room to room?

Walking stick
☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Zimmer frame
☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Wheelchair
☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Personal assistance
☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Bedridden
☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

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D Activities of daily living (ADL) continued

30) **Stairs** – Does the resident require assistance to climb and descend a staircase? (Please use your judgment if there are no stairs at the facility)

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

31) **Transfers** – the ability to transfer to and from a bed or chair.

Does the resident require any of the following?

Assistive device

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Personal assistance (1 person)

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Personal assistance (2 people)

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Mechanical device

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

32) **Toileting** – the ability to get on and off the toilet and maintain a reasonable level of hygiene.

Does the resident require personal assistance with this activity?

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

33) **Continence** – control over regular bowel and bladder function.

What is the position with the resident's bladder and bowel movements?

Bladder

☐ Continent ☐ Needs pads ☐ Catheterised, independent ☐ Catheterised, dependent

Bowel

☐ Continent ☐ Needs pads ☐ Incontinent ☐ Stoma, independent ☐ Stoma, dependent

Please describe the help required if applicable

34) **Washing and grooming** – the ability to maintain a reasonable level of cleanliness and appearance.

Does the resident require assistance with any of the following:

Bath/shower

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Sponge wash

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Clean teeth/shave/apply make-up

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

D Activities of daily living (ADL) continued

35) **Dressing** – the ability to dress and undress all appropriate clothing.

Does the resident require assistance with any of the following:

Assistive device

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Personal assistance

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

36) **Feeding** – the ability to consume food and drink which has been prepared and made available.

Does the resident require assistance with any of the following:

Assistive device

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

PEG

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Personal assistance

☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

Please describe the help required if applicable

37) Has the resident's ability to perform these activities reduced over the last 6 months?

☐ Stayed the same ☐ Reduced ☐ Significantly reduced

E Further information

38) Please provide any further details you feel may be relevant in support of your resident's application

Please enclose copies of any health needs assessment, pre-admission assessment, care plan or any hospital letters

Letters enclosed ☐

Signature

Date D D M M Y Y Y Y

Name

Position

Qualifications

Please return this report in the prepaid envelope provided to Legal & General Retirement, PO Box 809, Cardiff CF24 0YL

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