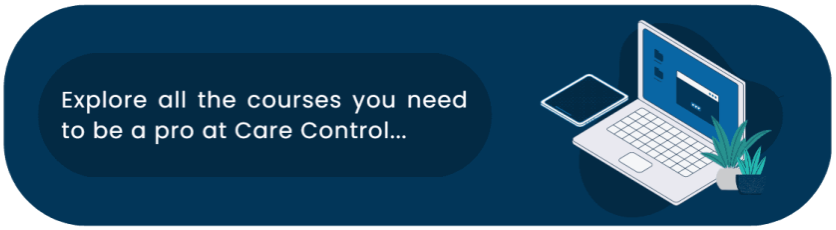
About Me & PRSB

Administration Windows · https://cclearninghub.co.uk/docs/about-me-and-prsb/



About Me & PRSB

We have been working with the **Public Records Standards Body** to ensure Care Control Systems data records are aligned to social care. **About Me** information is the most important details that a person wants to share with professionals in health and social care. This information might include how best to communicate with the person, how to help them feel at ease or details about how they like to take their medication.

About Me

Refers to the importance of ‘personal preferences’. **About Me** information is the most important details that an individual wants professionals in health and social care to know about them. It might include how best to communicate with the person, how to help them feel at ease reduce their anxiety, for example when having an injection, and who they would like to be with them.

About Me is really something that could help everyone; we all have a different story to tell. Information that does not seem a high priority for one of us might be particularly important for someone else, such as who is looking after a pet when the person is admitted to hospital.

People with complex needs could come to significant harm when crucial information about them is not understood or shared. This might include people with profound learning disabilities, dementia, physical disabilities, sensory disabilities, long term conditions, mental health conditions, and many

more.

Equally, many people feel overwhelmed with the amount of information and the number of professionals encountered on their health and care ‘journey’. In addition, some people have significant communication issues and detailing their story can be difficult and frustrating.

Another example of About Me information is clarity as to how a person takes their medication when a more conventional way is not possible, such as swallowing difficulties.

The expectation is that About Me information would be written or recorded by an individual (or someone supporting them)

Supported to write this by; where relevant refers, to record the name, relationship/role and contact details of the individual who supported the person to write their About Me Notes.

What is most important to me

- A description of what is most important to you:
- Emergency Information: – Include any essential information that any professional in the health and social care should know about you in any situation, including emergencies.
- Other Information: This could include values, spirituality/religion, ethnicity, culture, pets, goals and aspirations, meaningful activities including leisure activities, visiting places, sports, and exercise, listening to music, employment, education, volunteering.

People who are important to me

- Details of who is important to the individual and why.
- They could be family members, carers, friends, members of staff etc.
- Include how you want the people important to you to be engaged and involved in your care and support in both emergency and normal situations.
- Include how you stay connected to the people important to you.
- Who should not be contacted or consulted about your care and support and why if you wish to say.

How I communicate and how to communicate with me

- A description of how you communicate normally including any communication aids you use, for example, a hearing aid.
- Include your preferred language of communication, if your first language is not English.

- Include how you would communicate when you are in pain or distress.
- Include how you give feedback or raise a concern.
- Include how you like to receive information.
- Describe how you would like others to engage and communicate with you, including how you would like to be addressed.

My wellness

- A description covering what you can do, how you engage with others and how you feel on a typical day through to a day when you are unwell or really unwell.
- Include any causes that might result in you becoming unwell and strategies for avoiding or addressing the causes.
- For example, not drinking enough water could cause constipation.
- Include any signs that indicate you might be becoming unwell. On a bad day describe what is different about what you can do, how you engage with others and how you feel.
- Include how your everyday life is affected by any medical conditions e.g. dementia and any symptoms e.g. itchiness, cough, pain and how you manage those conditions. Include past health issues or experiences that need to be considered. Include your well-being and lifestyle goals and aspirations.

Please do and please don’t

- A description of things you want someone supporting you to do (or not to do).
- Things you want someone to do might include: talking to me, not to my carer, remind me to take my medication, encouraging me to wash my hands regularly, explain to me what is happening and why, and respond to my communication.
- A description of things you do not want someone supporting you to do might include: discussing or asking questions about certain topics, making assumptions about something, providing support when it is not wanted, talking to you in a certain way, undergoing a specific intervention or taking a medication the person does not want.

How and when to support me

- A description of how and when you want someone caring for you to support you.
- This could include support needs in an emergency situation (for example taking blood).
- This could include support you need to maintain important routines or to carry out particular activities, for example personal care routines, eating and drinking, bedtime routines, taking

medications, moving and transitioning.

- This could also include support needed with: wearing glasses/hearing aids/false teeth, making informed choices or understanding dangers and risks, managing your emotions, moods and behaviour, memory or confusion.
- Include how your support needs change in different environments.
- Include any triggers that might result in you needing further support and strategies for avoiding or addressing the triggers.
- Include how you want the support to be provided.

Also, worth knowing about me

- A description of what is also worth knowing about you for people caring or supporting you.
- This could include a short history of your life (where you have worked, where you lived, important events in your life, important people in your past life).
- This could include a short profile of your current life: your work / study, your aspirations, your skills, your networks, things you like e.g., particular foods, places, a football team and things you like to talk about, things you dislike.
- This could also include any care and support preferences that have not been included elsewhere.

Formulation Care Review Domain

To conform to the PRSB standards, Formulation has been added for accessibility as required. It is not necessarily for care professionals to populate, but rather to you know it is available in the Care Control system and where it can be found.

The formulation is a health professional expert domain name used by specific bodies, for example, mental health professionals, and psychologists.

It is used as an account, shared by a therapist and person, of the personal meaning and origins of a person’s difficulties. This is viewed in the context of multiple factors including relationships, social circumstances and life events and will indicate the most helpful way forward.

Contingency/safety plans	These are the things to do and people to contact, should an individual's health or other circumstances get worse for safety.
Trigger factors	Signs to watch out for that may indicate a significant change in health or other circumstances e.g. feeling agitated
Contingency plan name	When the action evaluation needs to be reviewed.
What should happen	Guidance on specific actions or interventions that may be required or should be avoided in specific situations. This may include circumstances where action needs to be taken if a carer is unable to care for the person. A statement of suggested actions. Usually expressed as: in the event of X do Y.
Who should be contacted	Who should be contacted in the event of significant problems or deterioration in health or wellbeing. e.g. name, role and contact details.
Agreed with person or legitimate representative	Indicates whether the plan was discussed and agreed with the person or legitimate representative.
Responsibility for review	This is who has responsibility for arranging review of this information. The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker, key worker, care home manager, care coordinator, LA hospital liaison person, care home contact, hospital clinician, Independent Mental Capacity Advocate (IMCA) etc
Coping strategies	Details of coping strategies used The coping strategies are defined as thoughts and behaviours that people use to manage the internal and external demands of situations that are appraised as stressful. This should also include a record of any tools used to carry out the coping strategy.
Relapse indicators / early warning signs	Details of the relapse indicators for the person. Any supplementary or personalised information regarding the relapse indicators/early warning signs.
Advance statement	Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity.

Strengths	Any strengths and assets the person has relating to their goals and hopes about their health and well-being.
Needs, concerns, or problems	Details of the person needs concerns or problems
Goals and hopes	The overall goals, hopes, aims or targets that the person has. Including anything that the person wants to achieve that relates to their future health and wellbeing. Each goal may include a description of why it is important to the person. Goals may also be ranked in order of importance or priority to the person.
Actions and activities	Actions or activities the person or others plan to take to achieve the person's goals and the resources required to do this.
What	What the action is and how it is to be carried out?
Who	Name and role (e.g. person, carer, GP, OT, etc.) of the person, or a team, carrying out the proposed action, and, if relevant where action should take place.
Status	The status of the action or activity e.g. in progress, done, refused
Stage goal	Details of the person's stage goals A specific sub-goal that is related to the overall goal as agreed by the person in collaboration with a professional.
Outcomes	Outcomes of each of the person's goals, aims and targets. Includes comments recorded by the person, date and status.
Care funding source	A reference to the funding source and any conditions or limitations associated.
Responsibility for review	This is a record of who has responsibility for arranging review of this information.