

Patient Acute Care Plan and Flow Chart

Patient Care Plan

Patient Details		General Practice Details	
Name		Practice name	
Date of Birth		Named GP	
NHS Number		Contact number	
Address		Address	

Acute plan completed by:	Date acute plan completed:	Date acute plan due for review:

Patient consent:	YES/NO
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Acute Care Plan Key Clinical Information

Key issues:	
Condition specific information and plans:	
Special requirements/disability:	
Problem list and medical history:	
Normal observations and functions (baseline):	
Social situation and preferred contacts:	
Additional information:	

Acute Care Plan

Specific information for ambulance crew:	
Conditions and parameters for escalation level 1a:	
Conditions and parameters for escalation level 1b:	
Conditions and parameters for escalation level 2:	
Conditions and parameters for escalation level 3:	

Escalation levels	Actions
1a – Remain at home – Ongoing remote monitoring Well, very mild symptoms (include examples and diagnostic parameters where applicable)	Self-care (including use of rescue packs) Consider 111
1b – Remain at home – primary care team and specialist advice Symptomatic but otherwise well and physiological state (include examples and diagnostic parameters where applicable)	Consider referral to: Community Resource Team and / or their Enhanced Community Care Provider or, District Nurse or Specialist Nurse (i.e. Respiratory, Diabetes, Frailty etc.)
2 – Deteriorating – Home based response or access to intermediate urgent care Deteriorating clinical or social condition that if worsening could lead to hospital admission (include examples and diagnostic parameters where applicable)	Contact - Health Board Single Point of Access or, GP or, 111
3 – Hospital attendance required Clinical and/or social situation requires care only available in hospital (define specific parameters)	Ambulance required - Access to hospital via required admissions unit/ process without the need for a GP referral