## **Care Homes Future Care Planning/ACP Quality Review**

## Key Information Summaries Quality Criteria: assurance and improvement

Resident's name	•••••
Resident's chi number	•••••
Resident's registered GP	

	Yes	No
Key Information Summary (KIS) available in the care home		
Clinical history or current clinical condition <sup>a</sup>		
Current functional status <sup>b</sup>		
Next of kin or Power of Attorney details		
Guidance for management of acute illness <sup>c</sup>		
CPR status documented <sup>d</sup>		
Preferred place of care <sup>e</sup>		

<sup>&</sup>lt;sup>a</sup> This might be a list of significant diagnoses or free text about their clinical condition in the special notes.

<sup>b</sup> Mobility, cognition, continence, and conversation are possible examples.

<sup>c</sup> "Not for admission to hospital in the event of a sudden collapse or stroke" would be one example. "Try to manage in care home if possible" would not be sufficiently specific to qualify.

<sup>d</sup> Is CPR status clear on the KIS? This will either be as a code for 'Do Not Attempt CPR' or as free text stating they wish resuscitation.

<sup>e</sup> "For admission to hospital in the event of an infection not responding to antibiotics" and "Try to manage in the care home if possible" would both qualify for this criterion.