



Torbay and South Devon
NHS Foundation Trust

Carers Health & Wellbeing Check Supporting Carers in Torbay



Introduction

This check is about looking after you as a Carer. It will focus on your own health and wellbeing and whether there are any areas you need support with. It is a chance to talk about your concerns and hopes for the future.

The check covers the questions which Carers have told us are important. You do not have to answer them all, but the more you fill in, the more you are likely to get out of the check.

It is really important that at the end of the discussion with the worker, you have all the relevant information and a clear plan of action to help you meet your own needs. The worker will help you decide how to put your plan into action.

The person you care for may be entitled to their own assessment of needs and support. This can be arranged separately - please just ask your worker.

As you complete the form you can make a note of things you want to do something about by putting a tick or comments on the side of the form.

All information is stored and shared in accordance with the Data Protection Act. It will only be shared with your consent and only for the purposes of supporting you to maximise your own health and well being.

This check is considered to be a 'light touch' Carer's assessment under the Care Act 2014.

If certain services are required, the worker may also complete eligibility and resource allocation forms.

This document can be made available in other languages and formats.
For information telephone 01803 208455.

Your General Health

Do you have any diagnosed illness or disability

Yes

No

If yes, please give brief details:

If yes, is this illness or disability being monitored and are you doing what was recommended?

Yes

No

Is there anything about your own health that worries you?

Yes


No


If yes, please give brief details:

Have you had an admission to hospital in the past year?

Yes

No

Tick ✓ if you want to do something about this. 

Tick ✓ if you want to do something about this. 

Checks Ups and Screening

Have you taken up the following health checks/vaccinations? (Please tick as appropriate)

Dentist (annual)

Yes No

Optician (annual)

Yes No NA

Audiology (hearing problems)

Yes No NA

Flu (annual)

Yes No

Pneumonia (one-off)

Yes No

Bowel Cancer (Age 60 – 69, every 2 years)

Yes No

Women

Cervical Cancer (Age 25-49 every 3 years, 50-64 5 years) Yes No NA


Breast Cancer (if at risk, or if over 50, every 3 years) Yes No NA

All adults

Chlamydia (sexually-transmitted disease, if appropriate) Yes No NA

Men

Aortic Aneurysm (aged 65+, one off) Yes No NA


Tick ✓ if you want to do something about this. 

Medication

Do you currently take any prescribed medications Yes No

If yes, do you have any problems with these medications (eg side effects) Yes No

Have you had a medication review in the past 12 months? Yes No NA

Tick ✓ if you want to do something about this. 

Caring Tasks

On average how many hours per week do you look after the person you care for?

1 – 19 hours 20 – 49 hours 50+ hours

Does your caring role involve you in moving / handling the person you care for or using equipment? Yes No

If yes, do you have any pain associated with this? Yes No

Would you like advice / training on using equipment or making caring safer for you? Yes No

Do you need information or advice on the condition of the person you care for? Yes No


Have you been given advice on financial benefits as a carer? Yes No NA

Do you receive Carers Allowance? Yes No

Have you had a Carers Assessment, One-off Direct Payment or Emotional Support Vouchers in the past?

If yes, please give details including date:

Yes No Unsure

Tick ✓ if you want to do something about this. 

Would you like support with:

Accessing employment or volunteering?

Yes No NA

Accessing education or learning?

Yes No NA


Accessing leisure opportunities

Yes No NA

Are there any caring tasks that you currently undertake that you would prefer not to, or are there any changes you would like to make?

Yes No NA

If yes please give details:

Tick ✓ if you want to do something about this. 

Do you need support in your caring role with practical things, such as:

Help with shopping, housework or cooking Yes No

Getting a break from caring/having time to myself Yes No

Advice on continence care Yes No

Advice on medication or treatment Yes No

Pressure ulcer prevention Yes No

Planning for emergencies Yes No


Fire safety and home security at home Yes No

Dealing with isolation, having contact with other carers Yes No

Talking to the person I care for or family about my caring role Yes No


Planning for the future Yes No

The Strains of Caring (World health Organisation Questions)

Tick ✓ if you want to do something about this. 

Please indicate for each of the five statements which is closest to **how you have been feeling over the last two weeks**. Notice that higher numbers mean better well-being.

| | At no time | Some of the time | More than half the time | Most of the time | All of the time |
|---|------------|------------------|-------------------------|------------------|-----------------|
| 1. I have felt cheerful and in good spirits | 1 | 2 | 3 | 4 | 5 |
| 2. I have felt calm and relaxed | 1 | 2 | 3 | 4 | 5 |
| 3. I have felt active and vigorous | 1 | 2 | 3 | 4 | 5 |
| 4. I woke up feeling fresh and rested | 1 | 2 | 3 | 4 | 5 |
| 5. My daily life has been filled with things that interest me | 1 | 2 | 3 | 4 | 5 |

Tick ✓ if you want to do something about this. 

Have you suffered a bereavement in the past year? Yes No

Has caring caused difficulties in your relationships with others close to you? Yes No

Would you like support with this? Yes No

As a Carer how well do you look after your own health and wellbeing?
Please rate on scale 1 – 5 (1 = not at all 5 = extremely well)

1 2 3 4 5

Have you any other issues or concerns not covered so far, or anything else that you or someone else could do to make a difference:

Your Lifestyle

What is your height?

What is your weight?

What is your waist measurement?

| | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| How often do you eat 5 portions of fruit and vegetables in a day? | Every day | Most days | Not often | Never |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Do you have a hot meal regularly? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

| | | | | |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| How many days do you eat fried food? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

| | | | | |
|--|-----|--------------------------|----|--------------------------|
| Would you like advice on healthy eating? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|--|-----|--------------------------|----|--------------------------|


| | | | | |
|---|-----|--------------------------|----|--------------------------|
| Do you or others have any concerns about your weight? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|---|-----|--------------------------|----|--------------------------|


| | | | | |
|--|-----|--------------------------|----|--------------------------|
| Do you take part in regular physical activity or exercise? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|--|-----|--------------------------|----|--------------------------|

How many hours per week?

| | | | | |
|-------------------------------------|-----|--------------------------|----|--------------------------|
| Would you like to do more exercise? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-------------------------------------|-----|--------------------------|----|--------------------------|

| | | | | |
|--|-----|--------------------------|----|--------------------------|
| If yes , would you like someone to contact you about support? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|--|-----|--------------------------|----|--------------------------|

Tick ✓ if you want to do something about this. 

Tick ✓ if you want to do something about this. 

Do you smoke at all? Yes No

If yes, how many per day?

If yes, would you like to stop smoking? Yes No

Have you tried to stop before? Yes No

Would you like someone to contact you to help you give up? Yes No

How often per week do you have an alcoholic drink?

Do you or does anyone else worry about your alcohol use? Yes No

If yes, would you like someone to contact you about support? Yes No

Are you concerned about any sexual health issues? Yes No

(eg pregnancy, contraception, sexually transmitted diseases, sexual relationships)

Would you like information about support on drug use (eg cannabis or abuse of prescription drugs)? Yes No

Summary Page - to be completed with worker

Situation; Background; Assessment Summary (what Carer does and how it affects them); Carers strengths and views; Recommendations.

Carers Action Plan

Your Name Date Of Birth

Worker's Name Lindsey Redhead Contact Details 07884735578

This section is to help you confirm what action you need to take or support you need from others, to improve or maintain your own health and wellbeing.

| Need - Information and Support | Action required | By whom | When |
|--|-----------------|---------|------|
| Outcome... | | | |
| Information given - Carers info/leaflets <input type="checkbox"/> Info re support to person Cared for <input type="checkbox"/> Info re practical support <input type="checkbox"/> | Type text here | | |
| Support for Carer - Carers Register <input type="checkbox"/> Carers Groups <input type="checkbox"/> Carers Courses <input type="checkbox"/> Lifestyles Support <input type="checkbox"/> Health Support <input type="checkbox"/> Employment Support <input type="checkbox"/> Caring for other children <input type="checkbox"/> | | | |

| Need - Emotional Support | Action required | By whom | When |
|---|-----------------|---------|------|
| Outcome... | | | |
| Someone to talk to - Professional Ongoing Carer Support Worker <input type="checkbox"/> Depression and Anxiety Support <input type="checkbox"/> Counselling/Emotional Support Scheme <input type="checkbox"/> | | | |
| Reduce Isolation - talk to other people Peer Support <input type="checkbox"/> Telephone Line Support <input type="checkbox"/> Counselling/Emotional Support Scheme <input type="checkbox"/> | | | |

| Need - A Break from Caring | Action required | By whom | When |
|---|-----------------|---------|------|
| Outcome... | | | |
| Improved finances Finance or benefit advice <input type="checkbox"/> Access Financial Support <input type="checkbox"/> | | | |

| Need - A Break from Caring - <i>cont.</i> | Action required | By whom | When |
|--|-----------------|---------|------|
| Outcome... | | | |
| Improved support to Person Cared for Refer on about their support <input type="checkbox"/> Practical Support <input type="checkbox"/> | | | |

| Need - Support for other People Affected | Action required | By whom | When |
|---|-----------------|---------|------|
| Outcome... | | | |
| Support for Carers under 25 <input type="checkbox"/> Support for any other Carers identified <input type="checkbox"/> Support with Childcare <input type="checkbox"/> | | | |

I agree that the information provided in my Check and Action Plan may be shared with Health and Social Care professionals who can contribute to my care. I understand that this information will be used for the purpose of providing a service or care to me.

Signed (Carer) **Lindsey Redhead Carer Support Worker,** received verbal consent from on Dated
..... to share information

Signed (Worker) **Lindsey Redhead** Dated