Suggested minimum content of care plans and patient-held records for hypertension

Tool **H13**

Care plans

Jointly agreed personal care plans should:

- be negotiated and agreed following a full explanation and discussion of the choices to be made between the person with hypertension (and/or their partner or carers, if appropriate) and the health professionals involved in that individual's care
- be set out in a way that is understandable and clear
- be kept in the patient's record and copied to the person with hypertension (and/or their partner or carers, if appropriate)
- be kept up-to-date
- set out the treatment plan, goals and management targets
- record blood pressure measurements, and give an explanation of how these relate to the goals and management targets
- specify what care the person should expect to support the treatment plan, who will provide it and where it will be provided
- advise on how to prevent and manage the complications of hypertension
- set the date of the next review.

Patient-held records

Records should contain as a minimum:

- background information on hypertension
- patient contact details, including those of the health professionals providing care
- medical and other relevant details
- treatment regime
- instructions for emergencies
- the care plan
- items to be covered at annual and other checks
- an education checklist
- a glossary of medical terms
- space for the patient's own notes.

Note: If a patient with hypertension has a co-morbidity, such as diabetes or coronary heart disease, the above information should be incorporated into their existing care plan and patient-held record.