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| Name: | Chandra Wickra (he/him) |  | |
| D.O.B: | 18/02/20XX |
| Partner / Spouse: |  |
| Next of Kin: | Anjali Wickra (mother) |
| Location or address: | 1. Suite 24 Banksia Disability Residential | 1. Medicare or DVA number: | 1. QSM36748XX |
| Doctors name: | 1. Dr. Maalik Ahmadi | 1. Doctors contact number: | 1. (03) 9XXX XXXX |
| Date ICP developed | 03 / 02 / 20XX | 1. Date of next review: | 1. 03 / 02 / 20XX |
| People involved: | Chandra Wickra (client), Steven Grozdanovski (Residential Manager), Deb Sinclair (Care Coordinator), Harry Jenkins (Personal Care Worker), Hamish Matao (Kitchen), Benjamin Hartley (Lifetsyle), Saskia Mitchell (Education) | | |
| Background information of client: | 1. Chandra is in his early twenties, has down syndrome, mild schizophrenia, asthma, and is obese. Over time he experienced declining mental health and increasing behaviours of concern that his family found difficult to manage. 2. Chandra attended a day program several times a week and still had contact with his siblings (who were not living at home). Over time, his siblings visited less and less due to his aggression and unbalanced mental health. 3. Chandra has been living in Banksia Disability Care for a few weeks now. He has recently experienced a bout of Bells palsy, - has finished course of cortisone, now recovering. Still has partial facial paralysis on left side of face. | | |
| Care alerts | Personality shifts, Physical Violence, Asthma, signs of depression | | |

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| **Communication** | | | |
| Preferred Name: | Chandra | | |
| Language spoke: | English, Sinhalese | | |
| Speech Disorders: | N/A | | |
| Comprehension: | Full comprehension | | |
| Specialist / Doctor: | N/A | Contact: |  |
| Comments: |  | | |

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| **Vision** | | | |
| Sight: | 20/20 vision | | |
| Glasses: | N/A | | |
| Diseases / Infections: | N/A | | |
| Aids (sticks / dogs): | N/A | | |
| Specialist / Doctor |  | Contact: |  |
| Comments: |  | | |

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| **Hearing** | | | |
| Aids: | N/A | | |
| Ear Care: | N/A | | |
| Diseases / Infections: | 1. N/A | | |
| Specialist / Doctor |  | Contact: |  |
| Comments: |  | | |

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| **Mobility** | | | |
| Ambulation: | Fully ambulant but due to obesity needs rest after 5 minutes of continuous exercise | | |
| Transfers: | N/A | | |
| Aids: | 1. N/A | | |
| Prosthetics: | 1. N/A | | |
| Specialist / Doctor: |  | Contact: |  |
| Comments: |  | | |

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| **Toileting** | | | | |
| Regime: | Independent Supervise Some assistance/remind Fully assist  Clean perianal area | | | |
| Bladder (control and management): | Continent Incontinent Catheter | | Encourage and remind to drink water / fluids and check at all mealtimes | |
| Bowel (control and management): | 1. Continent Incontinent Constipation 2. Colostomy | | 1. High fibre diet Aperients Bowel Chart | |
| Continence Aids: | 1. Day only Night only Both | | | |
| Toileting Aids: | 1. Commode Urinal Uridome Kylie 2. Bed pan Over toilet frame | | | |
| Specialist / Doctor | N/A | Contact: | | N/A |
| Comments: |  | | | |

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| **Personal Care (Showering, dressing, grooming)** | |
| Showering Regime: | Independent Supervise Some assistance/remind Fully assist  Bed wash only |
| Transfer |  |
| Showering Aids: | 1. Shower chair Relies on grab rails |
| Toiletries: | Normal soap  Low irritant products only  Cetaphil / QV / Aqueous / Aveeno / ONLY  Shampoo / Conditioner (Type: any )  Deodorant (Type: any )  Moisturiser (Type: any ) |
| Dressing Assistance | All Buttons Bra Socks / Shoe  Trousers Zips Makeup Accessories  Selection of clothing |
| Cultural Requirements: | N/A |
| Comments: |  |

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| **Sleep and Rest Care** | | | | | |
| Usual Time to Bed: | 1030pm | Usual Time to Wake: | 7am | Rest Time: |  |
| Aids: | Comforter Music Massage Night Light  Door open Door Closed TV on | | | | |
| Nighttime Checks: | 1. Hourly Two hourly Once Other | | | | |
| Nighttime Pattern: |  | | | | |
| Comments: |  | | | | |

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| **Skin Care** | | | |
| Norton Scale: | Low Risk (score >18) Medium Risk High Risk (between 14 and 10)   Very High Risk (score<10) | | |
| Daily Care: |  | Product: |  |
| Pressure Aids: | 1. Sheepskin Cushion Cradle Special Mattress | | |
| Pressure Area Regime: | Reposition in bed Reposition in chair Personal chair in communal lounge area | | |
| Specialist / Doctor | N/A | Contact: | N/A |
| Comments: |  | | |

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| **Medications – The Below is a Summary Only. Refer to Medication Register for Full Details.** | | | |
| Current Medications: | Antacids before meals | | |
| Regime: | Morning Midday Afternoon Evening Other: | | |
| BSL Testing: | 1. No Yes If yes, frequency: | | |
| Allergies: | 1. No Yes If yes, specify: | | |
| Asthma Management Plan: |  | | |
| Illnesses: |  | | |
| Normal GP: | Dr. Maalik Ahmadi | Contact: | 0411 223 334 |
| Comments: |  | | |

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| **Social / Emotional** | |
| Visitor information: | Parents and siblings visit once a week on Sundays. His mother sometimes visits for a short time on weekdays. |
| Religion: | Buddhist |
| Pastoral Care: | 1. Likes ot go with his mother to the Buddhist temple |
| Special Days: |  |
| Hobbies / Interests | Loves playing and watching football. Likes shopping and cooking. |
| Pets: | N/A |
| Community / Social: | Likes to go to the local football club from 8am to 5pm on Saturdays |
| Comments: |  |

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| **Domestic / Housekeeping** | |
| Shopping: | Depends on carers and his mother for all domestic duties except cooking |
| Washing: |  |
| Cleaning: |  |
| Transport: |  |
| Cooking: | Likes to cook |
| Gardening: |  |
| Pet Care: |  |
| Comments: |  |

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| **Eating and Drinking** | |
| Regime: | Independent Supervise Needs some assistance Fully assist  Right Handed  Left Handed |
| Preferred Place to Eat: | Dining Room |
| Type of Diet: | 1. Normal Soft Modified Soft Pureed |
| Special Diet: | High Fibre Diabetic Low Calorie High Calorie  Supplemented Enteral Feeding PEG/NGT |
| Thickened Fluids: | No Yes  If yes, what level?  Level 1 Level 2 Level 3 |
| Aids: | Modified Cup Modified Cutlery Clothing Protection Bowl  Meal Tray over Bed |
| Table Setting: |  |
| Cultural Requirements: |  |
| Allergies: |  |
| Favourite Foods: | Traditional Sri Lankan curries and food, fried foods, takeaway |
| Food Intolerances / Dislikes: |  |
| Snacks: | Only eats junk, won’t eat fruit unless in a smoothie with ice-cream etc. |
| Comments: | Is on a reduced calorie count diet |

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| **Specialised Care Plan** | |
| Please refer to Individual Action Plan for the following: | Medications Post-Surgical Occupational Therapy Nutrition  Wound Care Pain Management Mental Health Infectious Disease Management |

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| **Behaviours of Concern** | |
| Type | Food - bingeing |
| Description | Hordes junk food and then eats all in one sitting |
| Frequency / Duration | 1. Daily |
| Intensity | Medium |
| Setting events | When stressed, unhappy, after football if he plays poorly or the teams he follows play poorly |
| Triggers | Poor game of football, inability to do something (usually physical), |
| Low risk scenarios | General community events, activities, being around other people in the care facility |
| High risk scenarios | Straight after a football game; general physical activities |
| Function of the behaviour | To comfort himself |
| Functionally equivalent replacement behaviour | Replace junk food with healthier foods e.g. sultanas, dried apricot and other fruit |
| Behavioural goals (these should be observable and measurable and expressed in terms of the functionally equivalent replacement behaviour) | Reduced calorie intake diet and replacement foods when wanting to binge. |
| **IMPORTANT:** should this client require restrictive practices, a dedicated (NDIS) Behaviour Support Plan must be completed by the Disability Care Manager | |

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| **Behaviours of Concern <STUDENT TO ADD NOTES HERE>** | |
| Type | Choose an item. |
| Description |  |
| Frequency / Duration |  |
| Intensity |  |
| Setting events |  |
| Triggers |  |
| Low risk scenarios |  |
| High risk scenarios |  |
| Function of the behaviour |  |
| Functionally equivalent replacement behaviour |  |
| Behavioural goals (these should be observable and measurable and expressed in terms of the functionally equivalent replacement behaviour) |  |
| **IMPORTANT:** should this client require restrictive practices, a dedicated (NDIS) Behaviour Support Plan must be completed by the Disability Care Manager | |

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| **Care Plan Provided to:** | | | | | |
| Client | Yes ☐No | Family/Carer | Yes ☐No | Other services  (Doctor / Physio) | Yes ☐No |

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| **Client / Carer Acknowledgement:** | | | | |
| I understand and agree to this care plan: | | ☐Yes ☐No | | |
| Signed By: | Chandra Wickra | (**Client** or Carer) | Date: | 03 / 02 / 20XX |
| Name of Person Signing: | Chandra Wickra | (**Client** or Carer) | Date: | 03 / 02 / 20XX |
| Witness Signature: | Deb Sinclair | (**Care Coordinator** or Medical Authority) | Date: | 03 / 02 / 20XX |
| Witness Name: | Deb Sinclair | (Care Coordinator or Medical Authority) | Date: | 03 / 02 / 20XX |