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| **My current health issues include:** | | |
| **These are the treatments (excluding medications) I have and this is what I feel about them (for example: chiropody, bloods, pacemaker, opticians):** | | |
| **Print & sign name:** | **Date:** | |
| 1. **MEDICATIONS** | | |
| **To include:**   * **whether I’m able to take medication independently** * **how I feel about taking medications** * **any preferred time when I would like to take my medication** * **what special support I may need to help me to make decisions about whether or not to take medication** * **situations that cause me to have a negative reaction and how best to prevent these from happening, and what to do if they do happen (i.e. distress, agitation etc.)** * **any other medication requirements due to my health condition or some difficulties I experience (i.e. liquid form of medication, crushing, halving the tablet etc)** * **what my carers will do if there are any problems with my medications** * **do I have any medication allergy**   **\*For list of my medications please refer to my MAR chart** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **PAIN MANAGEMENT** | | |
| **To include:**   * **how I will express when I am in pain (verbal and non-verbal cues i.e. fidgeting, restlessness, rocking, patting, being withdrawn or tense, anxious, agitated, calling out, shouting, swearing, groaning, facial expression and body language that may suggest pain of discomfort)** * **how to help me manage the pain including a nonpharmacological intervention e.g.: massage, repositioning etc.** * **any specific time (before or after certain procedure or activity) or situation where I may be in pain or discomfort (e.g: prior to moving and handling, transfer, change of a dressing etc)** * **any chronic pain I experience**   **\*This care plan should be used in conjunction with C10a\_Pain Assessment for residents who are not able to communicate pain or C10b\_ Pain Assessment for residents who are able communicate pain as appropriate.** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **EATING & DRINKING, FOOD & NUTRITION** | | |
| **To include:**   * **what I am able to do independently** * **any support I need to eat and drink and to choose what to eat and drink** * **any specially adapted cutlery/crockery I need to use** * **any dietary needs and preferences I have and how to meet them (including food allergies, diabetes etc)** * **when I like to have my meals** * **what environment I prefer to have my mealtimes in (eg people, place, noise, light)** * **if I am at risk of under- or over- eating/drinking, how you will know (signs and symptoms) and how to help me stay healthy** * **if I am at risk of choking and how to help me if I am choking** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **COMMUNICATING** | | |
| **To include:**   * **how I tend to communicate (eg body language, facial expressions, words, gestures, noises, actions) and how best to understand me and what I am expressing** * **any support I need to communicate my wants and needs** * **eyes and vision, ears and hearing, memory and cognitive health** * **if I regularly have any unpleasant feelings (eg anger, anxiety, sadness & depression) and how to help me get through them** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **MOVING ABOUT (MOBILISATION & TRANSFERS)** | | |
| **To include:**   * **what I am able to do independently** * **how I tend to move around (eg walking, wheelchair, zimmer frame)** * **any support I need to move around and transfer** * **how I feel about moving around (eg confident, nervous)** * **any factors that affect how well I am able to move around** * **if I am at risk of falling and what to do if I fall** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **ELIMINATION AND USING THE TOILET** | | |
| **To include:**   * **what I am able to do independently** * **any support I need to empty my bladder/bowels** * **what support I need to stay dry and clean throughout the day and night** * **how I feel about my ability to use the toilet / empty my bladder & bowels** * **when I prefer to use the toilet /empty my bladder & bowels** * **how to look for signs of ill health relating to elimination and what to do if you see these signs** * **do I use catheter/stoma bag and what support do I need if I use it** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **SLEEPING AND NIGHT TIME CARE** | | |
| **To include:**   * **any support I need to go to sleep (eg hot drink, music, doll, lighting)** * **what environment I prefer to have at night time (eg door/window/curtains open/closed, music, lights on/off)** * **when I prefer to go to sleep** * **what I prefer to wear in bed** * **if I sleep well, and what tends to interrupt my sleep, what is my sleeping pattern** * **how to support me during the night** * **what time I prefer to wake up and get up in the morning** * **do I prefer to have a rest/nap in the afternoon** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **WASHING, DRESSING & SKINCARE** | | |
| **To include:**   * **what I can do independently** * **any support I need to have a wash (upper body, lower body, hair, teeth/denture)** * **what I can do myself and any support I need to get dressed (upper body, lower body)** * **any support I need and my preferences regarding shaving** * **any support I need and my preferences regarding my nails (length, colour)** * **what clothes I prefer to wear (including colour)** * **any support I need to keep my skin in good condition and moisturised** * **how to look for signs of ill health relating to my skin and what to do if you see these signs** * **where and when I prefer to get washed & dressed and have my skincare attended to** * **whether I prefer a male or female carer to help me** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **EXPRESSING SEXUALITY** | | |
| **To include:**   * **how I express my sexual needs (touching others, holding hands, cuddling, flirting, watching pornography, sexual stimulation, making comments of sexual nature and other)** * **am I happy to share information about my sexuality or I would like to keep this information private (for example information about sexual orientation)** * **how to ensure me and my carers have dignity and safety at all times relating to sexuality** * **do I have anyone I am intimate with** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| 1. **MY END OF LIFE PREFERENCES** | | |
| **To include:**   * **what treatments and medical interventions I want and do not want to happen at the end of my life, do I have an advance decision to refuse treatment** * **who I want around me at the end of my life** * **my preferred environment at the end of my life (eg in my room, music, curtains open)** * **what I want to engage in at the end of my life (eg massage, being read to, music)** * **how I feel about death and dying, my thoughts and fears**   **\*For more information about my preferences regarding the end of life care please see A3 (ACP/ECP form)** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |
| **11. ENGAGEMENT AND WELL-BEING** | | |
| **To include:**   * **what activities of daily living would I like to be doing?**   Ideas: cleaning my shoes, housework, personal grooming, using the telephone   * **is there anything related to my previous occupation that I would enjoy doing/I’m able to do?** * **what skills do I have? This is what I enjoy doing…**   Ideas: I am creative, I enjoy playing games such as…, I speak other languages, I like talking about…; music I enjoy is….   * **I am interested in exploring new activities such as….**   Ideas: Skype and computers, crafts, discussion groups, physical fitness, musical activities   * **where do I enjoy being?** (i.e. in my own space, with others, outside…) **and what places do I like to visit?** (i.e. galleries, shops, tourist attractions, parks) * **what time of day do I like to be engaged / do I like to relax?** (when I have the most energy in the day?) * **people or objects that I feel attached to and what I need to help me feel close to them** * **other information about what I like to do and what I don’t like to do** | | |
| **My needs and plan of care:** | | |
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| **Print and sign name:** | | **Date:** |

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| **Signs of Ill-being** | **Signs of Well-Being** |
| * **despair** * **anger** * **grief** * **anxiety** * **fear** * **boredom** * **physical discomfort** * **bodily tension** * **agitation** * **apathy** * **withdrawal** * **cultural alienation** * **difficulty withstanding powerful others** | * **assertiveness** * **bodily relaxation** * **sensitivity to the needs of others** * **humour** * **creative self expression** * **helpfulness** * **initiating social contact** * **showing affection** * **signs of self respect** * **expression of a range of emotions** * **positive mood** * **positive engagement and occupation** * **showing pleasure** |

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| **12. SPIRITUALITY** | |
| **To include:**   * **what does spirituality and religion means for me** * **do I observe religious festivals** * **are there any \*Yahrzeits I wish to observe and the dates** * **do I want to go to the synagogue and when** * **do I pray and when and where I prefer to do it** * **any support I need to meet my spiritual needs** * **people or objects that I feel attached to, things that I like to look at, touch or hold that have special meaning or that feel important to me (e.g. in nature, buildings, images, statues, medals and pendants, prayer book, \*mezuzah,)**   \*Yahrzeits – on the anniversary of the death of a parent, sibling, child, or spouse it is the custom to light a memorial light in the bedroom of the resident. The light remains for 24 hours. The Yahrzeits “candles” are electric plug in candles available from Unit Manager or Religious Advisor Rafi. No real candles to be lit in rooms.  \*Mezuzah - is a piece of parchment (often contained in a decorative case) on the doorposts, inscribed with specified Hebrew verses from the Torah; | |
| **My needs and plan of care:** | |
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| **Print and sign name:** | **Date:** |