|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT DETAILS** | | | | | | | | | | | | | |
| First Name: «firstName» | | | | | Surname:«surname» | | | | | | | D.O.B:«dateOfBirth» | |
| Clients prefers to be addressed as:«preferredName» | | | | | | | | | | | | | |
| Current Address: «streetAdress» | | | | | | | | | | | | | |
| Suburb:«suburb» | | | | | | | | | | | | P/Code: «postCode» | |
| Permanent Address: as per procura | | | | | | | | | | | | | |
| Mobile: «mobileNumber» | | | Ph: 08 «homePhone» | | | | | Email: «email» | | | | | |
| Gender: «gender» | | | Country of Birth: «countryOfBirth» | | | | | | | | | | |
| Marital Status: «maritalStatus» | | | | | | | | | | | | | |
| Carer Status: «carerStatus» | | | | | | | | | | | | | |
| Living Arrangements: «livingSituation» | | | | | | | | | | | | | |
| Residence Type: «accomodationType» | | | | | | | | | | | | | |
| Special Needs Group: Veteran ☐ CALD ☐ ATSI ☐ LGBTQI+ ☐ not stated ☐ | | | | | | | | | | | | | |
| Indigenous Status: «atsiStatus» | | | | | | | | | | | | | |
| Languages spoken: «language» | | | | | | | | | | | | | |
| Pensioner Status: «pensionStatus» | | | | | | | | | | | | | |
| Pension Type | «pensionTypeIncome» | | | | | Other: ☐ Please specify: | | | | | | | |
| Pension No: «pensionNumber»  Expiry Date: | | | | | | | | Medicare No: «medicareNumber»  Expiry Date: «medicareExpiry» | | | | | |
| DVA No: «dvaNumber» | | | | «dvaType» | | | | | | Health Insurance: «privateHealth» | | | |
| Centrelink Aged Care Fees Income Assessment form completed: | | | | | | | | | «incomeAssetsTest» | | | | |
| Assigned HCP | | ☐ Level 1 | | | | | ☐ Level 2 | | | | ☐ Level 3 | | ☐ Level 4 |
| Highest HCP Approval | | ☐ Level 1 | | | | | ☐ Level 2 | | | | ☐ Level 3 | | ☐ Level 4 |
| MAC AC: «ACnumber» | | Other MAC Approvals: as per MAC | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FORMAL SUPPORT NETWORK** | | | | | | | |
| «epgStatus» | | | | | | | |
| «epaStatus» | | | | | | | |
| «ahdStatus» | | | | | | | |
| «epaEpgAcp» «advanceCarePlanningComments» | | | | | | | |
| **GP and Specialist Care Providers** | | | | | | | |
| GP: «doctor» | | | | | Ph: | | |
| Specialist: «specialist» | | | | | Ph: | | |
| Pharmacy: «pharmacy» | | | | | Ph: | | |
| Other: | | | | | Ph: | | |
| **MEDICAL/CLINICAL HISTORY** | | | | | | | | |
| **Medical and Health Diagnosis** *(MAC Summary)* | | | | | | | | |
| **«medicalCurrent»**  **«medicalHistory»** | | | | | | | | |
| **Previous Medical History** *Hospitalisations, Surgery, Specialist Referrals* | | | | | | | | |
| **«recentHospitalisations»,**  **«surgicalHistory»**  **«medicalOther»** | | | | | | | | |
| Any in home/Outpatient treatments and frequency: | | | | | | | | |
| Covid – 19 Vaccinated: | | | «covidStatus» | | | | | |
| How many Covid-19 vaccinations have you had: | | |  | | | | | |
| Influenza Vaccinated: | | | «fluVaxStatus» | | | | | |
| Date of last vaccination: | | | «vaccineComments» | | | | | |
| Pain Management: ☐ Yes ☐ No | | | «painLocation» «painFutherAssessment» «painOther» | | | | | |
| **Managing medications** *– how medications are managed* *e.g., remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments* | | | | | | | | |
| Capacity: | | | «medicationSupport»  «medicationList»  «highRiskMedications»  «hmr»  «medicationOther» | | | | | |
| Allergies: medicines, food, bandages | | | «allergiesDrug»  «allergiesFood» | | | | | |
| Skin Integrity and Wound Care: | | | «woundCare»  «pressureInjury»  «skinIntegrity» | | | | | |
| **CONTINENCE MANAGEMENT** | | | | | | | | |
| Do you have accidental or involuntary loss of Bladder/Bowel motion?  If yes continue with below questions | | | **«eliminationUrinary»**  **«eliminationBowel»**  **«Toileting»**  **«eliminationOther»**  **«eliminationReview»** | | | | | |
| Have you had a continence assessment recently? | | | **«continenceAssessmentStatus»** | | | | | |
| If yes, do you have a management plan?  Ask for a copy or for details (this includes CMAS) | | | ☐ Yes | | | ☐ No | | |
| CMAS Details: | | | | | | | | |
| If no, would you like one to be organised with our clinical team. | | | ☐ Yes | | | ☐ No | | |
| Incontinence aids currently used:  **«incontinenceAids»** | | | | | | | | |
| No. day x | | Type | | Size | | | absorbency | |
| No. night x | | Type | | Size | | | absorbency | |
| Specialist Services Required: | | Urinary Catheter/Stoma care | | ☐ Yes ☐ No | | | | |
| **SLEEP AND RESPIRATORY FUCNTION** | | | | | | | | |
| How Many hours sleep do you get at night? | | | | | | | | |
| Do you experience any nocturia? | | | | | | | | |
| Do you sleep during the day? | | | | | | | | |
| Sleep Disorders: Do you experience any sleep disorders e.g., insomnia, sleep apnea, restless legs syndrome ☐ Yes ☐ No  «sleep» | | | | | | | | |
| If yes, please advise: | | | | | | | | |
| Specialist Services Required: | Oxygen therapy  Tracheostomy care | | ☐ Yes ☐ No «oxygen»  ☐ Yes ☐ No | | | | | |
| **COGNITION/BEHAVIOUR** | | | | | | | | |
| Memory and Recall ability: Is the client able to remember recent and past events, perform tasks in steps and recall caregiver names? ☐ Yes ☐ No | | | | | | | | |
| Cognitive skills: Has the client experienced any cognitive decline that affects and/or reduces their ability to make everyday decisions ☐ Yes ☐ No | | | | | | | | |
| Does the client have any formally diagnosed cognitive impairment: ☐ Yes ☐ No If yes, do not complete Cognitive Exam – Mini-Cog™  If yes, discuss dementia supports: Alzheimer’s WA, Dementia Australia etc.  «cognitionNeurological»  «depression»  «psychologicalOther»  «mmseStatus»  «psychgeriatricAssessmentScaleStatus»  «hierarchicDemetiaScaleStatus» | | | | | | | | |
| Cognitive Exam – Mini-Cog™  ☐ Yes ☐ No ☐ N/A  Please complete if there are no formal diagnoses of cognitive impairment, but there are reported concerns about the clients cognition.   1. Ask the client to repeat the following words, Banana, Sunrise, Chair 2. Ask the client to draw a clock face including the hands on the clock for the time 11:10 3. Ask the client to repeat the words in step 1 after completing step 2   Step 1 = 1 pt for each word recalled  Step 2= 2pts for correct instruction. 0 pts for inability to follow instruction or refusal to follow instruction.  Total score = Word Recall score + Clock Draw score.  A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.  Final Score:  Clinical Referral for further evaluation: ☐ Yes ☐ No | | | | | | | | |

|  |  |
| --- | --- |
| **INFORMAL SUPPORT NETWORK** | |
| Carer: Yes ☐ No ☐ | Co-resident carer ☐ Yes Non-Co resident carer ☐ Yes |
| Who lives with you: | Primary Carer: ☐ |
| Provided assistance (what support provided and how often is support provided)  Do family or friends assist with any support services? | Identified Care Need: |
| Able to continue caring activities.  ☐ Yes ☐ No why i.e. stressed | Identified Care Need: |
| Carers WA/Carer Gateway referral required.  ☐ Yes ☐ No |  |
| Spouse: | Children: |
| Grandchildren: | Siblings: |
| Friends: | Pets: |
| Neighbours: | Other:  Eg: Church members/ Community. |
| **SOCIAL DOMAIN** | |
| Spiritual / Faith / Religious Services: «religiousImpact» | |
| Cultural needs: «culturalImapact» | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **COMMUNICATION** | | | | |
| What is the Client’s primary language? «language»  What other languages does this person speak? | | | | |
| Making self-understood – expressing information content, both verbal and non-verbal | | | | |
| «makingSelfUnderstood» | | | | |
| Ability to understand others | | | | |
| «understandingOthers» | | | | |
| **AUDITORY (Hearing)** | | | | |
| **HEARING** | Yes | No | **Identified Care Need:** | |
| Does this person have an identified hearing deficit |  |  |  | |
| Speaks very loudly |  |  |  | |
| Tinnitus (ringing in the ear) |  |  |  | |
| History of ear infections |  |  |  | |
| Wears a hearing aid R L |  |  |  | |
| If yes, can the Client fit aids by themselves |  |  |  | |
| Can Client clean and replace batteries |  |  |  | |
| Ability to hear (with hearing appliance normally used) | | | | |
| ☐ **Adequate –** No difficulty in normal conversations, social interaction, listening to tv  ☐ **Minimal difficulty** – difficulty insome environments (e.g., when person speaks softly or is > 2 metres away)  ☐ **Moderate difficulty** – problem hearing normal conversation, requires quiet setting to hear well  ☐ **Severe difficulty** – difficulty in all situations (e.g., speaker must talk loudly or speak very slowly)  ☐ **No hearing** | | | | |
| **VISION (Sight)** | | | | |
| **SIGHT** | **Yes** | **No** |  | **Identified Care Need:** |
| Wears glasses and type |  |  |  |  |
| Can clean and fit own glasses |  |  |  |  |
| Ability to see in adequate light (with glasses or with another visual appliance normally used) | | | | |
| ☐ **Adequate** – sees fine detail including regular print in books or newspapers  ☐ **Minimal difficulty** – sees large print, but not regular print in newspapers / books  ☐ **Moderate difficulty** – limited vision, not able to see newspaper headlines, but can identify objects  ☐ **Severe difficulty** – Object identification in question, but eyes follow objects; sees only light, colours, shapes etc.  ☐ **No vision** | | | | |

|  |  |  |
| --- | --- | --- |
| **RISK FACTOR CHECKLIST** | | |
| **VISION/HEARING:**  Reports/observed difficulty seeing - objects/signs/finding way around; uncorrected visual impairment/does not wear visual aids as recommended | «fallsRiskFactorVision» | |
| **MOBILITY:**  Mobility status unknown or appears unsafe/impulsive/forgets gait aid/requires assistance | «fallsRiskFactorMobility» | |
| **TRANSFERS:**  Transfer status unknown or appears unsafe i.e., over-reaches, impulsive; Requires assistance with transfers | «fallsRiskFactorTransfers» | |
| **FALLS RISK Identifier** | | |
| «fallsRisk»  «fallsOther» | | |
| **History of Falls (Note: For an Accurate history, consult client / family / medical records)** | | |
| **CIRCUMSTANCES OF KNOWN FALLS: For each fall record**: Dates; Type (Trip; Slip; Lost balance; Collapse; Leg/s gave way; Dizziness); location; other key information i.e., how information was received (client/staff), etc. | | |
| **ACTION PLAN** | | |
| **Identified Risks:** | | As above |
| Refer to physiotherapist for comprehensive mobility assessment and plan | | «ptReferralStatus» |
| Refer to occupational therapist for functional assessment  «ptReferralStatus»«otReferralStatus» | | «otReferralStatus» |
|  | |  |
|  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MOBILITY** | | | | |
| 1. Primary mode of Locomotion See below   ☐ Walking, no assistive device  ☐ Walking, uses an assistive device – e.g., walker, stick, crutch, self-propelled wheelchair  ☐ Wheelchair, scooter  ☐ Bed bound   1. Distance able to walk- farthest distance walked in one time without sitting down in the last 3 days   «DistanceToWalk»   1. Wheelchair – farthest distance wheeled self at one time in the last 3 days (includes motorised wheelchair)   ☐ Wheeled by others  ☐ Used motorised wheelchair or scooter  ☐ Wheeled self (distance) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ n/a | | | | |
| **Mobility Aids and Equipment Assessment** | | | | |
| **Assess** | | | | **Outcome** |
| General Mobility | | | | ☐ Independent ☐ Supervision ☐ Limited ☐ Severely limited ☐ Physical assistance  «mobilityOther» |
| Weight Bearing | | | | ☐ Safe ☐ Variable ☐ non-weight bearing ☐ Physical assistance |
| Ambulation | | | | «transfers» «ambulation» «mobilityAids»  «transfersOutside» «ambulationOutside» «mobilityAidsOutside» |
| Transferring | | | | As above |
| Moving in Bed | | | | ☐ Independent ☐ Supervision ☐ Prompt ☐ Physical assistance See below  Type of aid/degree of assistance: |
| Client is Usually | | | | ☐ left handed ☐ right handed |
| **ADL’s – Activities of Daily Living - for all capacity that is not “independent” is an assessed care need** | | | | |
| **Bathing** – how client takes a full body shower/ bath, includes how transfers in and out and how each body part is washed – arms, upper /lower legs, chest, abdomen, perineal area (excludes washing of back and hair) | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required «PersonalCareOther» | | |
| Identified care need: | | | | |
| Showering frequency: | | | | Time: |
| Hair washing frequency: | | | | Shave Frequency: |
| Routine: | | | | |
| **Personal Grooming/Dressing** – how client manages personal hygiene/ dresses and undresses including brushing hair, brushing teeth, shaving, applying makeup, washing, and drying face, and hands, prostheses, orthotics, fasteners, pullovers, pants skirts, socks, shoes. – Excludes bath and showers. | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required | | |
| Identified Care Need: | | | | |
| **Toilet use** – how client uses the toilet room (or commode, bedpan, urinal) cleanses self after toilet use or incontinent episodes, changes pad, manages ostomy or catheter, adjusts clothes, - excludes transfers on and off toilet. | | | | |
| Capacity  ☐  ☐ | Independent – No help, setup, or supervision  Assistance required «Toileting» | | | |
| Identified Care Need: | | | | |
| **Stairs** – how do you navigate stairs | | | | |
| Capacity | | «Stairs» | | |
| Identified Care Need: | | | | |
| **Bed mobility** – *how client moves to and from lying position, turns from side to side, and position of body while in bed* | | | | |
| Capacity | | «BedMobility» | | |
| Identified Care Need: | | | | |
| **FUNCTION – for all capacity that is not “independent” is an assessed care need** | | | | |
| **Shopping** *– how shopping is performed for food and household items (e.g., selecting items, paying money what devices are in use and what is level of capacity to use independently then identified care needs* | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required  «shoppingOther»«shoppingOther»«shoppingOther» | | |
| Identified Care Need: | | | | |
| **Ordinary housework** – How ordinary housework around the house is performed (e.g.) doing dishes, dusting, making bed, tiding up, laundry. | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required «cleaningAndHGM» | | |
| Identified Care Need: | | | | |
| **Meal preparation** – How many meals are prepared e.g., planning, assembling ingredients, cooking, setting out food and utensils | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required  «mealsOther» | | |
| Identified Care Need: | | | | |
| **Managing finances** – how bills are paid, household expenses are budgeted, credit card account is monitored. | | | | |
| Capacity  ☐  ☐ | | Independent – No help, setup, or supervision  Assistance required «financesOther» | | |
| Identified Care Need: | | | | |
| **Phone use** – how telephone calls are made or received (with assistive devices, such as large numbers amplification is needed what devices are in use and what is level of capacity to use independently then identified care needs | | | | |
| Capacity  ☐  ☐ | | «mobilePhoneUse» | | |
| Identified Care Need: | | | | |
| **SOCIAL AND COMMUNITY PARTICIPATION** | | | | |
| **Social engagement** *– What do you participate in and how often* | | | | |
| Social Activities:  «socialOther» | | | | |
| Capacity  ☐  ☐ | | Independent  Assistance required | | |
| How Satisfied are you with your current level of social interactions (scale 1 to 10, with 1 being dissatisfied and 10, being very satisfied? | | | | |
| Are you seeking support to engage in social activities? ☐ Yes ☐ No | | | | |
| Identified Care Need: | | | | |
| **Transportation** *– how client travels by public transport (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicle.* *what devices are in use and what is level of capacity to use independently then identified care needs do valid licence are you still driving* | | | | |
| Driving | | | «Driving» | |
| Capacity  ☐  ☐ | | | Independent – No help, setup, or supervision  Assistance required | |
| Is formal transport assistance is required? | | | | |
| Transport  supports | | | | ACROD Sticker ☐ TUSS voucher ☐ Cab charge ☐ Not stated ☐  «transport» |
| Transport options | | | | Independent ☐ Family/Friends ☐ Taxi ☐ Southern Plus ☐ St John’s Transport ☐ |
| Vehicle requirements: | | | | n/a ☐ Low mobility vehicle ☐ Vehicle walker appropriate ☐ Wheelchair Accessible ☐ |
| Identified Care Need: | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EATING AND DRINKING **Assessment** | | | | | **Yes** | | **No** | **NA** | **Identified Care Need:** |
| Can plan and prepare own meals | | | | |  | |  |  |  |
| Buys pre-made meals | | | | |  | |  |  |  |
|  | | | | | | | | | |
| Likes (include cultural preferences): NA | | | | | | | | Dislikes: NA | |
| Diet: | | ☐ Regular ☐ Diabetic ☐ Special (specify): **«swallow»** | | | | | | | |
| Food Texture: Self managing  IDDSI Level:  Level 7 Texture – Solid(crunchy, chewy, lumpy) ☐ Level 6 Texture – Soft/Bite-Sized ☐  Level 5 Minced/Moist ☐ Level 4 – Pureed ☐ Level 3 – Liquidised ☐ | | | | | | | |
| Fluid Consistency: | | IDDSI Level: Self managing  0 -Thin/normal ☐ 1- Slightly thick ☐ 2- Mildly Thick ☐ 3- Moderately Thick ☐ 4- Extremely Thick ☐ | | | | | | | |
| Daily fluid Intake (mls) | |  | | | | | | | |
| **Eating –** *how clients eat, and drinks (regardless of skill) includes intake of nourishment by other means e.g., tube feeding, total parenteral nutrition)*  «eating» | | | | | | | | | |
| Capacity | ☐ Independent – No help, setup, or supervision  ☐ assistance – Setup and/or supervision including prompting to eat or assistance with enteral tubes (tube feeding, total parenteral nutrition) | | | | | | | | |
| **NUTRITION:**  Underweight / low appetite | | ☐ Yes ☐ No | | **Identified care need: «nutritionalIntake»** | | | | | |
| Weight loss in last 6 months | | ☐ Yes ☐ No | | **Identified care need: «mst» «oral»** | | | | | |
| Requires Dietician review: «dieticianReferralStatus» | | | | | | | | | |
| Dentition: Does the client have dentures ☐ Yes ☐ No «oral»  If yes, please specify: ☐ Upper ☐ Lower ☐ Both | | | | | | | | | |
| Requires Speech Pathologist review: Any issues with speech and/or swallowing. «speachReferralStatus» | | | | | | | | | |
| Diabetes Management: ☐ Yes ☐ No ( If yes, please complete remaining check boxes)  Diabetes Type 1 ☐ Diabetes Type 2 ☐ refer to medical section | | | | | | | | | |
| Insulin dependent: ☐ Yes ☐ No | | | If yes, Capacity: | | | Independent ☐ Assistance required ☐ refer to medication management | | | |
| BGL: ☐ Yes ☐ No | | | If yes, Capacity: | | | Independent ☐ Assistance required ☐ | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Task** | **Independent** | **Supervise** | **Assist x1** | **Assist x2** | **n/a** | **Task** | **Independent** | **Supervise** | **Assist x1** | **Assist x2** | **n/a** |
| **Dress/Undress** | | | | | | **Toileting** | | | | | |
| Choose appropriate garments |  |  |  |  |  | Put toiletries away |  |  |  |  |  |
| Undergarments on/off |  |  |  |  |  | Put toiletries away |  |  |  |  |  |
| Vest / Petticoat on/off |  |  |  |  |  | Wash/dry hands |  |  |  |  |  |
| Shirt / Cardigan on/off |  |  |  |  |  | Toileting (positioning on toilet) |  |  |  |  |  |
| Trouser / Skirt on/off |  |  |  |  |  | Use toilet paper independently |  |  |  |  |  |
| Socks / Stockings on/off |  |  |  |  |  | Adjust clothing independently |  |  |  |  |  |
| Zips / Buttons undo/do up |  |  |  |  |  | Change own continence aid |  |  |  |  |  |
| Shoes / Slippers on/off |  |  |  |  |  | **Grooming** | | | | | |
| **Hygiene** | | | | | | Wash hair |  |  |  |  |  |
| Initiate washing / Showering |  |  |  |  |  | Shave (men) |  |  |  |  |  |
| Collect toiletries and towel |  |  |  |  |  | Apply makeup (women) |  |  |  |  |  |
| Turn on tap |  |  |  |  |  | Put on wristwatch / jewellery |  |  |  |  |  |
| Adjust water Temperature |  |  |  |  |  | Clean, cut & file fingernails |  |  |  |  |  |
| Use wash cloth |  |  |  |  |  | Clean, cut & file toenails |  |  |  |  |  |
| Wash reachable parts |  |  |  |  |  | **Hearing and Sight** | | | | | |
| Wash feet, back |  |  |  |  |  | Hearing aids put in-situ |  |  |  |  |  |
| Wash perineal area |  |  |  |  |  | Glasses put on in-situ |  |  |  |  |  |
| Dry reachable parts |  |  |  |  |  | **Eating and Drinking** | | | | | |
| Dry feet, back |  |  |  |  |  | Cutting up meal, pour drinks |  |  |  |  |  |
| Dry perineal area |  |  |  |  |  | Positioning Client for meal |  |  |  |  |  |
| Apply moisturiser |  |  |  |  |  | Positioning cutlery and crockery |  |  |  |  |  |
| Insert / remove dentures |  |  |  |  |  | Initiating eating / drinking |  |  |  |  |  |
| Clean own teeth / dentures |  |  |  |  |  | Physically feeding Client |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SERVICE PLAN (Service Previsions Required) | | | | | | | |
|  | Mon | Tues | Weds | Thurs | Fri | Sat | Sun |
| MORNING | «mondayAM» | «tuesdayAM» | «wednesdayAM» | «thursdayAM» | «fridayAM» | «saturdayAM» | «sundayAM» |
| AFTERNOON | «mondayPM» | «tuesdayPM» | «wednesdayPM» | «thursdayPM» | «fridayPM» | «saturdayPM» | «sundayPM» |
| EVENING | «mondayEve» | «tuesdayPM»«tuesdayEve» | «wednesdayEve» | «thursdayEve» | «fridayEve» | «saturdayEve» | «sundayEve» |

|  |
| --- |
| **Service Requirements** Support staff preferences (likes, dislikes, gender, culture, ethnicity etc.  **Public Holiday Services:** ☐ Yes ☐ No TBA as they come up  If yes, please specify type of services to be held on public holidays. |
| Service provisions to be cancelled i.e., CHSP, STRC, gardening etc. |

|  |  |  |
| --- | --- | --- |
| **HEALTH AND SAFETY** | | |
| **Environmental Factors**  Do you or anyone else in the home smoke? ☐ Yes ☐ No  Are there any pets in the home? ☐ Yes ☐ No  Environmental Factors: (cameras, other people or pets living in the home, home condition etc.)  **Environmental Safety**  Pendant alarm: «persStatus»  Locked box access ☐ Yes ☐ No  (if yes, when, and where can staff access and what is code):  «keySafeLocation» «keySafeCode» Environmental Safety: (Any hazards observed, identified, or reported)   Home modifications required: Any grab rails installed?  Installed: «otherEquipmentUsed»  «homeModificationsInstalled»  Required: «otherEquipmentRequired»  «homeModificationsRequired»  Home Safety Hazard Identification Checklist Completed: YEs | | |
| **EMERGENCY PLANNING** | | |
| Non-response to a scheduled visit:  ***Expected outcome: in an event of a possible emergency all Southern Plus Staff will know my wishes*.**  ***If I do not answer the door to a scheduled visit, I want Southern Plus to.***  ***Select one or more.***  «notHome»  ***If Southern Plus staff are unable to gain access to my home or contact me or my emergency contact/s they are to:***  «notContactable»  ***If Southern Plus staff find me unwell and needing medical attention, they should:***  «ifUnwell»  «emergencyPlanningOther» | | |
| **SHARED RISK PLAN – refer to care plan** | | |
| **Purpose: Develop an agreed shared risk plan to support the client’s dignity of risk, quality of life and care by engaging collaboratively with clients and their nominated representatives, regarding choices that impact on safety.**  **Actions: Clarify risk(s) consider options and mitigation strategies.**  **Goal: Support individual preference and dignity of risk, maximise quality of life and care and reduce potential for harm.**  Client Nominated Activity (What the client would like to do/not do):  Client Goal (Why I have chosen this and what I hope to achieve):  Possible Associated Risk/s of Choice or Activity:  Actions/Mitigation Strategies:  Shared Risk Plan Review Date (6 monthly reviews unless concerns raised/changes noted before):  Next Review Date: | | |
| **CLIENT PROFILE** | | |
| Client back story/history:  «aboutMe»  What matters: «whatMatters»  Bad Day:«badDay»  Good day: «goodDay» | | |
| Likes:  «likesDislikes» | Dislikes: | |
| My Strengths: «strengths» | | |
| Short term goals: refer to care plan  Motivation to achieve: ……………../10  Client strategies:  Southern Plus strategies: | Long term goals: refer to care plan  Motivation to achieve: ……………../10  Client strategies:  Southern Plus strategies: | |
| Home Care Package Level: as per agreement  Dementia supplement: ☐ Yes ☐ No TBA  If yes, include strategies that are supporting the client’s needs with dementia in their care plan.  Further assessment required, refer to support plan | | |
| **NEXT ACTIONS** | | |
| Actions: refer to dated notes.  «communicationAssessmentStatus»  «continenceAssessmentStatus»  «depressionScreenStatus»  «fallsRiskAssessmentStatus»  «functionalAdlAssessmentStatus»  «hierarchicDemetiaScaleStatus»  «MedicationManagementAssessmentStatus»  «mmseStatus»  «painAssessmentStatus»  «pressureInjuryRiskAssessmentStatus»  «psychgeriatricAssessmentScaleStatus»  «ptReferralStatus»  «otReferralStatus»  «gpReferralStatus»  «podiatryReferralStatus»  «dieticianReferralStatus»  «speachReferralStatus»  «nursingReferralStatus»  «referralsComments»  Services: refer to dated notes.  Referrals:  Physio: «ptReferralStatus»  OT: «otReferralStatus»  GP: «gpReferralStatus»  Podiatry: «podiatryReferralStatus»  Comments: «referralsComments» | | |
| **CHECKLIST** | | |
| **Discussed with client** | | **Yes/ No** |
| ACAT assessed needs | | x Yes ☐ No |
| Southern Plus menu of service | | X Yes ☐ No |
| BDF, ITF, Management fees | | X Yes ☐ No |
| Budget and ITCF explained | | X Yes ☐ No |
| Overview of Service Agreement | | X Yes ☐ No |
| Consent and privacy | | X Yes ☐ No |
| Aged Care Charter of Rights | | X Yes ☐ No |
| Explain the guidelines in relation to hospital, social and respite leave | | X Yes ☐ No |
| Conduct WHS assessment and discuss any issues identified | | X Yes ☐ No |
| **ASSESSOR DETAILS** | | |
| **Assessor Name: Jon Morrell** | | **Designation: WP** |
| **Signature:** | | **Date: 27/06/2024** |