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| **CLIENT DETAILS** | | | | | | | | | | | | | |
| First Name: John | | | | | Surname:Cooke | | | | | | | D.O.B:1947-07-28 | |
| Clients prefers to be addressed as: | | | | | | | | | | | | | |
| Current Address: 185 16 Leeuwin Boulevard | | | | | | | | | | | | | |
| Suburb:West Busselton | | | | | | | | | | | | P/Code: 6280 | |
| Permanent Address: as per procura | | | | | | | | | | | | | |
| Mobile: 0403 161 192 | | | Ph: 08 | | | | | Email: | | | | | |
| Gender: Male | | | Country of Birth: | | | | | | | | | | |
| Marital Status: Married | | | | | | | | | | | | | |
| Carer Status: Co resident carer | | | | | | | | | | | | | |
| Living Arrangements: Lives in a couple | | | | | | | | | | | | | |
| Residence Type: ILU-retirement villiage | | | | | | | | | | | | | |
| Special Needs Group: Veteran ☐ CALD ☐ ATSI ☐ LGBTQI+ ☐ not stated ☐ | | | | | | | | | | | | | |
| Indigenous Status: Neither ATSI | | | | | | | | | | | | | |
| Languages spoken: English | | | | | | | | | | | | | |
| Pensioner Status: Full | | | | | | | | | | | | | |
| Pension Type | Aged pension | | | | | Other: ☐ Please specify: | | | | | | | |
| Pension No: 602-665-876H  Expiry Date: | | | | | | | | Medicare No: 61176076881  Expiry Date: 2025-01-01 | | | | | |
| DVA No: | | | | NA | | | | | | Health Insurance: No private health cover | | | |
| Centrelink Aged Care Fees Income Assessment form completed: | | | | | | | | | Completed | | | | |
| Assigned HCP | | ☐ Level 1 | | | | | ☐ Level 2 | | | | ☐ Level 3 | | ☐ Level 4 |
| Highest HCP Approval | | ☐ Level 1 | | | | | ☐ Level 2 | | | | ☐ Level 3 | | ☐ Level 4 |
| MAC AC: AC59470336 | | Other MAC Approvals: as per MAC | | | | | | | | | | | |

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| **FORMAL SUPPORT NETWORK** | | | | | | | |
| Client has EPG? , Yes, details provided | | | | | | | |
| Client has EPA? , Yes, details provided | | | | | | | |
| Client has AHD? , Yes, details provided | | | | | | | |
| EPA and EPG Uploaded. He has an Advanced Health Directive but is making changes, WP to follow up at next check in. | | | | | | | |
| **GP and Specialist Care Providers** | | | | | | | |
| GP: Dr. McDonnell, Sunshine Medical Centre, Busselton | | | | | Ph: | | |
| Specialist: Coastal Palliative Care  Rheumatologist- Prof Rob Will | | | | | Ph: | | |
| Pharmacy: | | | | | Ph: | | |
| Other: | | | | | Ph: | | |
| **MEDICAL/CLINICAL HISTORY** | | | | | | | | |
| **Medical and Health Diagnosis** *(MAC Summary)* | | | | | | | | |
| **John's medical conditions impact his functioning and mobility. He experiences declining endurance, increasing fatigue and shortness of breath requiring continuous oxygen therapy. John is currently under the palliative care team for symptom management of his lung disease. His condition is deteriorating, he is receiving medication to maintain his comfort and is nursed in bed and is supported by Coastal Palliative Care.**  **Pain, Asbestosis, Depression and mood affective disorders, Rheumatoid Arthritis, Psoriasis, Fracture of Femur, Back problems.** | | | | | | | | |
| **Previous Medical History** *Hospitalisations, Surgery, Specialist Referrals* | | | | | | | | |
| **,**  **His GP visits weekly and medications are currently delivered to his home.** | | | | | | | | |
| Any in home/Outpatient treatments and frequency: | | | | | | | | |
| Covid – 19 Vaccinated: | | | Covid status , Current | | | | | |
| How many Covid-19 vaccinations have you had: | | |  | | | | | |
| Influenza Vaccinated: | | | Flu vaccine status , Current | | | | | |
| Date of last vaccination: | | | Joy and John report that John has a good relationship with their GP who does home visits and follows up with vaccinations. | | | | | |
| Pain Management: ☐ Yes ☐ No | | | ACAT John experience's pain in his lower back from a spinal fusion, he reports feeling uncomfortable breathing and has discomfort in his neck. His pain is managed with regular schedule 8 medications, he is visited by the palliative team weekly. Pain assessment completed | | | | | |
| **Managing medications** *– how medications are managed* *e.g., remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments* | | | | | | | | |
| Capacity: | | | Carer supports client with medication  Client/carer to follow up HMR with GP  Joy assist John with his medication administration as he is very fatigued and short of breath (SOB), he is on strong, schedule 8 medications for pain. Has clinical support via Coastal Palliative Care service with medication and symptom management. | | | | | |
| Allergies: medicines, food, bandages | | | Bactrim, Celecoxib  Dairy/Milk | | | | | |
| Skin Integrity and Wound Care: | | | No wounds  ACAT he is a high risk of pressure sores and will require pressure care and relieving aids in the future  John reports he moves in bed often. He showed me a sheepsking that is not medical grade that he and joy had place there for pressure relief. | | | | | |
| **CONTINENCE MANAGEMENT** | | | | | | | | |
| Do you have accidental or involuntary loss of Bladder/Bowel motion?  If yes continue with below questions | | | **Uses 1x pad daily for incontinence.**  **occasional fecal incontinence due to mobility impairments.**  **Requires assistance with toileting**  **John requires help getting to the toilet at times due to his SOB, Joy assists. He wears pullups in case he does not make it to the toilet on time, help to change which Joy assist with.** | | | | | |
| Have you had a continence assessment recently? | | | **Continence Ax , Not required** | | | | | |
| 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:  **AbriFLex 6D M1 pants or Molicare mobile medium 6D** | | | | | | | | |
| 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  Sleeping day and night, he is very fatigued. | | | | | | | | |
| If yes, please advise: | | | | | | | | |
| Specialist Services Required: | Oxygen therapy  Tracheostomy care | | ☐ Yes ☐ No Needs:NA  Supplement:NA  ☐ 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.    John remained positive throughout the interview and realistic about his current circumstances.  John has good understanding and knowledge of his current and past medical issues. He is supported by Joy due to declining health. Has been noted to become "muddled" at times, "emotional and teary"  MMSE , Not required  Psychogeriatric Ax scale , Not required  Hierarchic Dementia Scale Ax , Not required | | | | | | | | |
| 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 | | | | | | | | |

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| **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: No religious concerns impacting on service delivery. | |
| Cultural needs: No cultural concerns impacting on service delivery. | |

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| **COMMUNICATION** | | | | |
| What is the Client’s primary language? English  What other languages does this person speak? | | | | |
| Making self-understood – expressing information content, both verbal and non-verbal | | | | |
| Understood – expresses ideas without difficulty | | | | |
| Ability to understand others | | | | |
| Understands – understands ideas without difficulty | | | | |
| **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** | | | | |

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| **RISK FACTOR CHECKLIST** | | |
| **VISION/HEARING:**  Reports/observed difficulty seeing - objects/signs/finding way around; uncorrected visual impairment/does not wear visual aids as recommended | Vision , No | |
| **MOBILITY:**  Mobility status unknown or appears unsafe/impulsive/forgets gait aid/requires assistance | Mobility , Yes | |
| **TRANSFERS:**  Transfer status unknown or appears unsafe i.e., over-reaches, impulsive; Requires assistance with transfers | Transfers , Yes | |
| **FALLS RISK Identifier** | | |
| No falls in last 12 months - (0)  Completely dependent with instrumental activities of daily living (eg cooking, housework, laundry)(3)  moderately unsteady (needs supervision) (2)  4 - 9 High risk of falls - Perform the Full FROP-Com assessment and / or corresponding management recommendations  History of falls: no falls in last 12 months | | |
| **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 | | PT referral , Not required |
| Refer to occupational therapist for functional assessment  PT referral , Not requiredOT referral , Not required | | OT referral , Not required |
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| **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   less than 5 meters   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  John has a history of falls, he has an unsteady gait, he is not walking much at the moment only a few steps around the house. For distances he requires a wheelchair. John requires assistance with transfers due to deteriorating health and fatigue, Joy helps with bed transfers and shower transfers, he has rails and uses furniture for support. |
| Weight Bearing | | | | ☐ Safe ☐ Variable ☐ non-weight bearing ☐ Physical assistance |
| Ambulation | | | | Standby assist transfers inside the home. Standby assist ambulation inside the home. Walking stick,Four wheeled Walker,Wheel chair for longer distances  Physical assist transfers outside the home. Standby assist ambulation outside the home. Wheel chair for all ambulation |
| 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 John requires assistance with showering due to declining health and SOB, supported by carers and Joy. | | |
| 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 Requires assistance with toileting | | | |
| Identified Care Need: | | | | |
| **Stairs** – how do you navigate stairs | | | | |
| Capacity | | Assistance- e.g., with grab rail or mobility aides standby etc | | |
| 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 | | Independent – No help, setup, or supervision | | |
| 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  John is unable to manage any shopping tasks, he has taken to his bed due to his deteriorating, palliative condition. Joy completes grocery shopping via online delivery. John is unable to manage any shopping tasks, he has taken to his bed due to his deteriorating, palliative condition. Joy completes grocery shopping via online delivery. John is unable to manage any shopping tasks, he has taken to his bed due to his deteriorating, palliative condition. Joy completes grocery shopping via online delivery. | | |
| 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 John is SOB and unable to endure any physical tasks. | | |
| 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  SOB and unable to endure any physical tasks. Joy has been supporting long term with meals. | | |
| 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 Joy is managing finances since Johns health deteriorated. | | |
| 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  ☐  ☐ | | Independent – No help, setup, or supervision | | |
| Identified Care Need: | | | | |
| **SOCIAL AND COMMUNITY PARTICIPATION** | | | | |
| **Social engagement** *– What do you participate in and how often* | | | | |
| Social Activities:  Joy has asked if during the SSI/Respite that our SW could take John for a walk around the village in the wheelchair. | | | | |
| 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 | | | No | |
| 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 ☐  John needs an ambulance for transport due to his deteriorating condition and declining mobility. |
| 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: | | | | |

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| 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): | | | | | | | |
| 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)*  soft diet | | | | | | | | | |
| 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: ACAT - Poor appetite eats small serves and snacks, he reports feeling nauseous. John drinks lots of fluids and take nutritional supplements regularly. He has lost a lot of weight as his condition has progressed towards palliative.** | | | | | |
| Weight loss in last 6 months | | ☐ Yes ☐ No | | **Identified care need: The significance of the amount of weight loss will depend on the body weight of the resident. For instance, a 3kg weight loss in a 40kg resident is significant Dentures upper and lower. Some looseness.** | | | | | |
| Requires Dietician review: Dietician referral , Completed | | | | | | | | | |
| Dentition: Does the client have dentures ☐ Yes ☐ No Dentures upper and lower. Some looseness.  If yes, please specify: ☐ Upper ☐ Lower ☐ Both | | | | | | | | | |
| Requires Speech Pathologist review: Any issues with speech and/or swallowing. Speach pathologist referral , Not required | | | | | | | | | |
| 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 ☐ | | | |

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| **Task** | **Independent** | **Supervise** | **Assist x1** | **Assist x2** | **n/a** | **Task** | **Independent** | **Supervise** | **Assist x1** | **Assist x2** | **n/a** |
| **Dress/Undress**  **Upper body dressing: , Supervise/standby assist**  **Lower body dressing: , Supervise/standby assist**  **Shoes and socks: , Partial assist**  **Zips and buttons assist , Supervise/standby assist** | | | | | | **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**  **Initiate/set up for shower: , Partial assist**  **Select clothing: , Independent**  **Adjust water temperature: , Supervise/standby assist**  **Washing overall: , Partial assist**  **Washing hard to reach areas (feet/back): , Full assist**  **Drying overall: , Partial assist**  **Drying hard to reach areas (feet/back): , Full assist**  **Perineal hygiene: , Supervise/standby assist** | | | | | | **Grooming**  **Mouth/teeth care: , Independent**  **Hair washing: , Full assist**  **Shaving: , Partial assist**  **Finger nail care: , Partial assist**  **Toe nail care: , Podiatrist** | | | | | |
| 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 |  |  |  |  |  |

John requires assistance with showering due to declining health and SOB, supported by carers and Joy.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SERVICE PLAN (Service Previsions Required) | | | | | | | |
|  | Mon | Tues | Weds | Thurs | Fri | Sat | Sun |
| MORNING | Personal care 30min |  | Personal care 30min |  | Personal care 30min |  |  |
| AFTERNOON |  | Social Support/Respite 2 hours weekly |  | Cleaning/SS/Respite 2 hours weekly |  |  |  |
| EVENING |  | Social Support/Respite 2 hours weekly |  |  |  |  |  |

|  |
| --- |
| **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: Personal Emergeny Response System , Not required  Locked box access ☐ Yes ☐ No  (if yes, when, and where can staff access and what is code):  Rear of unit between sliding doors In Procura Environmental Safety: (Any hazards observed, identified, or reported)   Home modifications required: Any grab rails installed?  Installed: Shower chair/stool,Over toilet seat,Hospital bed  Railing toilet,Railing bathroom,Ramps  Required:    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.***  Call my home phone,Call my mobile,Call my next of kin  ***If Southern Plus staff are unable to gain access to my home or contact me or my emergency contact/s they are to:***  Do not contact emergency services  ***If Southern Plus staff find me unwell and needing medical attention, they should:***  Contact Ambulance services  Client is always with someone. Plans for hospice admission if Joy not able to provide support at home. | | |
| **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:  John was born in Devon, England, he was a Fitter and Blacksmith in the Engineering field. John moved to New Zealand in 1971 for work and met his wife Joy. They moved to Perth, Australia in 1989 and later to Busselton to be near to their daughter Michele and her family. John and Joy have been together for 50 years, they have 3 children (Michelle -Margaret River, Shane -Canada and Kirsten in New Zealand). Joy has been caring for John in an increasing capacity over the past 20 years since his diagnosis of asbestosis and his chronic back condition. John's lung disease has gradually progressed over the years, he is being managed with a palliative treatment approach now.  What matters: To have the support I need to live at home for as long as possible.  For Joy to have respite.  To receive the right care at the right time, I have a plan to seek hospice support when I am no longer able to be cared for at home. This has been discussed with the palliative care service who will support this decision when the time comes. | | |
| Likes:  John has enjoyed painting, playing Squash, using the computer and was a member of a Bonsai Club. He loves being around his grandchildren and watches documentaries on TV when feeling up to it.  John likes the outdoors and going for a ride in the wheelchair on warmer sunny days. | Dislikes: | |
| My 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.  Communication Ax , Not required  Continence Ax , Not required  Depression screen , Not required  Falls Risk , Required  Functional ADL Ax , Not required  Hierarchic Dementia Scale Ax , Not required  Medication management Ax , Not required  MMSE , Not required  Pain Ax , Completed  Pressure injury risk Ax , Required  Psychogeriatric Ax scale , Not required  PT referral , Not required  OT referral , Not required  GP referral , Not required  Podiatry referral , Required  Dietician referral , Completed  Speach pathologist referral , Not required  Nursing referral , Required  dietician review has been completed needs follow up for supplements. John has appropriate mobility aids and is not a candidate for HEP. WP to discuss nursing assessment in view of falls and pressure injury risk.  Services: refer to dated notes.  Referrals:  Physio: PT referral , Not required  OT: OT referral , Not required  GP: GP referral , Not required  Podiatry: Podiatry referral , Required  Comments: dietician review has been completed needs follow up for supplements. John has appropriate mobility aids and is not a candidate for HEP. WP to discuss nursing assessment in view of falls and pressure injury risk. | | |
| **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: 24/07/2024** |