Complete relevant sections of the support plan as they relate to the client; blank sections indicate that support is not provided. Make a note to refer to medication plan, clinical/complex care plan or other specific plan.

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| Date of Birth: | 28/07/1947 | Name: | John Cooke | | Date: | 19/07/2024 | |
| BACKGROUND | | | | | | | |
| Who am I, summary of life history/story/interests | | | | | | | |
| About me: 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 and dislikes: 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. | | | | | | | |
| OVERALL HEALTH | | | | | | | |
| Medical History: | | | Identified Health Risks: | Mobility Support: | | | Communication Support: |
| Pain, Asbestosis, Depression and mood affective disorders, Rheumatoid Arthritis, Psoriasis, Fracture of Femur, Back problems. | | | Receiving nursing services (such as wound management),Unlikely to be able to relocate without assistance,Socially or geographically isolated  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. | Standby assist transfers inside the home.  Physical assist transfers outside the home.  Standby assist ambulation inside the home.  Standby assist ambulation outside the home.  Mobility aids: Walking stick,Four wheeled Walker,Wheel chair for longer distances | | | Hearing impaired,Vision impaired (glasses)  John wears glasses for reading, he is not wearing hearing aids due to weight loss they do not fit any more. John is very SOB, he struggles to converse often using body language and short answers  Wears bifocal glasses  Support workers will support John with communication by speaking clearly and not shouting, facing John when speaking, reducing the distance between them and John, reducing background noise, rephrase the sentence as needed, checking to see that John has understood what has been communicated. |

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| EMERGENCY RESPONSE PLAN |
| 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;  **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** |
| Specific instructions for me |
| Key safe location:  Key safe number:  My emergency planning preferences (in order): |

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| **Shared Risk 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 I (or client name) would like to do/not do** | | NA | | | |
| **Client Goal:**  **Why I have chosen this and what I hope to achieve** | | NA | | | |
| **Possible Associated Risk/s of Choice or Activity** | | | **Actions/Mitigation Strategies  (The examples below can be considered/adapted, along with client specific interventions)**  **NA** | | |
| NA | | | NA | | |
| Shared Risk Plan Review Date 6 monthly review (unless concerns raised/changes noted before) | | | Next date: | | |
| This Shared Risk Plan has been discussed and agreed to with the (tick as appropriate)  Client  Representative/Carer | | | | | |
| Client/Carer/Client Representative Name: | | | Signature: | | Date: |
| Wellness Partner Name: Jon Morrell | | | Signature: | | Date: |
| Clinical Coordinator/RN Name: Jon Morrell | | | Signature: | | Date: |
| IDENTIFIED NEED | GOAL  What does client want to achieve? | | CLIENT/CARER IS ABLE TO / WHAT WILL THEY DO | WHAT WILL SOUTHERN PLUS STAFF OR CONTRACTORS DO | WHAT WILL WELLNESS PARTNER DO |
| **COGNITION:**  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" | John will report he feels safe and secure at all times.  John will engage in meaningful activity on a daily basis and effectively complete all of his activities of daily living. | | John is able to independently make contact with people via phone and other electronic means.  John is able to access services such as . - Beyond Blue Support Service, 1300 22 46 36 and Web Chat; - Lifeline, 13 11 14; - Suicide Call Back Service, 1300 659 467 | SCC staff will provide john with support with memory and orientation.  Provide encouragement and reminiscence therapy. |  |
| **PERSONAL SAFETY:**  John has very limited mobility and requires 24/7 support/supervision.  John requires support to relocate in an emergency.  Johns home is fitted with smoke detectors and RCDs. | John will have the ability to gain timely access to emergency services as needed.  John will be demonstrate emergency response preparedness and have a plan in place in the event of a fire or other emergency situation. | | Joy will ensure that John has someone with him at all times so that he has access to support and assistance in case of an emergency situation.  Joy will support herself and John to have a plan for evacuation in case of an emergency and will access information to inform planning via DFES.  Joy will arrange for annual checking of safety devices within the home. |  |  |
| **PERSONAL CARE:**  John requires assistance with showering due to declining health and SOB | John will report he is maintaining a satisfactory level of personal hygiene/dress and grooming. | | John will continue to do what he can for himself during personal care services. | Southern Plus support workers will assist John with personal care 3 days per week.  Personal care details:  - Please be guided by client and wife Joy as to what level of care is required  - Full assist shower or bed bath  - Currently client will sit in shower and is able to mostly wash himself, requires assistance with hard to reach areas back, legs. Same with drying and dressing.  - Dry and dress on seat in bathroom  -prompt and assist John to apply moisturiser to his arms and legs.  - Client will most likely go back to bed after  - Tidy bathroom following shower. |  |
| Continence: 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. | Continence: John will maintain social continence. | | Continence: Joy will support John with toileting and personal hygiene | Continence: SCC will supply incontinence aids to manage incontinence and prevent skin breakdown. Molicare Mobile medium 6 drop.  SCC support workers will support John with toileting and persona hygiene when they are providing social support/respite services. | Continence: The Wellness Partner will order pads as and when requested to ensure delivery within 2 weeks time frame.  The Wellness Partner will facilitate continence assessment when there are changes to Johns care needs. |
| **MEDICATION MANAGEMENT:**  John requires support to 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. | John's medication will be managed safely and effectively | | Joy will support John to manage and take medication in consultation with his GP.  Joy will support John to remain in touch with the SW Coastal Palliative care service. |  | Wellness Partner will liaise and collaborate with SW Coastal Palliative care service and clients GP to ensure care needs are met. |
| **NUTRITION:**  John has a 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. John is unable to manage any shopping tasks, he has taken to his bed due to his deteriorating, palliative condition. | John and Joy will report that they are able to manage weekly shopping and meal preparation needs. | | Joy completes grocery shopping via online delivery.  John's family will support John with meal preparation.  John will contribute to the set up, cost of the food portion of and ongoing ordering of home delivered meals. | Southern Plus will facilitate the provision of prepared and home delivered meals through light and easy.  SCC will provide access to nutritional supplements as prescribed by a dietician | WP will follow up clients dietician to determine need for nutritional supplements. |
| **DOMESTIC ASSISTANCE:**  John is SOB and unable to endure any physical tasks.  Self care deficit related to maintenance of safe, accessible outdoor areas and access to the home secondary to frailty. | Johns home environment will be maintained in a clean and tidy state.  Johns home will be accessable and safe | | Joy will support John with lighter daily household tasks and cleaning. | Southern Plus support workers will provide assistance with cleaning fortnightly for 2 hours.  DOMESTIC ASSISTANCE:  - Strip and remake bed - assist with washing and hanging out.  - Clean bathroom and toilet.  - Vacuum throughout and mop hard floors.  - Assist with other OSH appropriate tasks as required, time permitting.  SCC will support client to attend to home maintenance and gardening that he would have ordinarily been able to attend to himself prior to age related decline in function. This will be within the capacity of budget, unspent funds and as needed. |  |
| **FUNCTIONAL SAFETY IN THE HOME ENVIRONMENT:**  John uses home oxygen.  John's home is well designed and laid out.  John maintains his home in a safe condition.  John does not live in a bush fire prone area. | Environmental risks will be identified, reduced/mitigated. | | Joy and John will perform their own risk and hazard assessments and seek support from WP to manage these when identified. | SCC staff will conduct risk assessment at each home visit and report hazards and incidents.  SCC staff will follow guidelines for safety in the home when oxygen concentrator/bottles are in use. | Wellness Partner will ensure that John has current up to date information about fire safety in the home or information on where to access this.  Wellness Partner will ensure that John has current up to date information about oxygen use safety in the home or information on where to access this. |
| **PSYCOSOCIAL SUPPORT:**  John is at risk of social isolation secondary to increasing frailty and mobility deficits.  John reports that he has lost interest in attending social groups and activities other than with family.  John states he enjoys getting out doors in fine weather. | John will have the opportunity to access the outdoors in fine weather on a daily basis. | | Joy will support John to access the outdoors in his wheelchair on days that there are not support workers coming in. | Southern Plus support workers will provide extra companionship/social interaction during support services. They will take John outdoors in his wheel chair to get some sunshine and fresh air. |  |
| **TRANSPORT:**  John needs an ambulance for transport due to his deteriorating condition and declining mobility. | John will be able to access the community to attend medical and allied health appointments. | | Joy will contact St Johns Ambulance when John needs to be transported. |  |  |
| **MAINTAINING PHYSICAL ACTIVITY & FUNCTION:**  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. He has rails and uses furniture for support. | Falls will be prevented.  John will report he feels safe and confident when ambulating and during transfers.  All manual handling tasks will be able to be completed in a safe and comfortable manner. | |  | SCC staff will assist John with transfers and ambulation as per mobility section. |  |
| **RESPITE:**  High risk of carer strain related to Johns high care and supervision needs | Joy will report that she feels less burdened, has more time to attend to her own health, social and or personal needs and goals. | | Joy has access to respite through her own access to carer and aged care services. | Southern Plus will provide services to ensure that Joy is able to attend to her own care needs and respite. |  |
| **CLINICAL CARE/**  **ALLIED HEALTH SUPPORT**  **John is being reviewed weekly by the SW Coastal Palliative care team**  **Potential falls and pressure injury risk identified.**  **John is not able to attend to his own foot care.** | **John will experience good long term foot health. Foot complications, such as infections will be prevented or identified early and treated.** | |  | Southern Plus will facilitate regular 8 weekly podiatry services. | Pressure injury risk - WP to discuss referral for nursing assessment.  Falls risk - WP to discuss referral for follow up assessment. |

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| **WELLNESS PARTNER RESPONSIBILITIES** | An individualised home care budget and care plan will be provided and discussed with the client / representative on each occasion there is a change in ongoing care and support services.  Co-ordinating care and services, including external contractors, processing invoices for payment.  Ensure care and services are culturally appropriate.  Complete a formal review of services being provided at least every 6 months, (sooner if client circumstances change) to ensure that directed and responsive services are delivered to meet the ongoing care needs of the client.  Address identified risks to client safety |

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| SERVICE PLAN | | | | | | | |
|  | 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 fortnightly |  |  |  |
| EVENING |  |  |  |  |  |  |  |

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| PARTICIPANTS INVOLVED IN DEVELOPMENT OF SUPPORT PLAN | |
| Client/Carer/Client Representative Name: |  |
| Signature: |  |
| Wellness Partner Name: | Jon Morrell |
|  | |
| This Support Plan has been discussed and agreed to with the (tick as appropriate)  Client  Representative/Carer | |
| Client agrees to the service provider contacting their nominated emergency contact if required  Yes  No | |