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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Birth: | «dateOfBirth» | Name: | «firstName» «surname» | | Date: | 24/01/2023 | |
| BACKGROUND | | | | | | | |
| Who am I, summary of life history/story/interests | | | | | | | |
| About me: «aboutMe»  Important People: «importantPeople»  What matters: «whatMatters»  A good day: «goodDay»  A bad day: «badDay»  Strenghths: «strengths»  Likes and dislikes: «likesDislikes» | | | | | | | |
| OVERALL HEALTH | | | | | | | |
| Medical History: | | | Identified Health Risks: | Mobility Support: | | | Communication Support: |
| «medicalHistory» | | | «risk»  «medicalCurrent» | «transfers»  «ambulation»  Mobility aids: «mobilityAids» | | | «CommunicationImpairements»  «communicationSupportPlanFactors»  «CommunicationAids»  «communicationSupportPlanInterventions» |

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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;  **«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»** |
| Specific instructions for me |
| Key safe location: **«keySafeLocation»**  Key safe number: **«keySafeCode»**  My emergency planning preferences (in order): **«emergencyPlanningOther»** |

| 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:**  «psychologicalSupportPlanFactors» |  |  |  |  |
| **PERSONAL SAFETY:** | «personalSafetySupportPlanGoals» |  |  |  |
| **PERSONAL CARE:** |  |  |  |  |
|  |  |  | Continence: «eliminationSupportPlanInterventions» |  |
| **MEDICATION MANAGEMENT:**  «medicationSupportPlanFactors» | «medicationGoals» | «medicationSP\_Client» |  |  |
| **NUTRITION:**  «mealsAndShoppingSupportPlanFactors» |  |  |  |  |
| **DOMESTIC ASSISTANCE:**  «cleaningSupportPlanFactors» | «cleaningSupportPlanGoals» |  |  |  |
| **FUNCTIONAL SAFETY IN THE HOME ENVIRONMENT:**  «environmentSupportPlanFactors» | «environmentSupportPlanGoals» |  |  |  |
| **PSYCOSOCIAL SUPPORT:** |  | «socialSP\_CLient» |  |  |
| **TRANSPORT:**  «transportFactors» | «transportGoals» |  |  |  |
| **MAINTAINING PHYSICAL ACTIVITY & FUNCTION:** |  |  | «mobilitySupportPlanInterventions» |  |
| **RESPITE:** | «carerSupportPlanGoals» |  |  |  |

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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 | «mondayAM» | «tuesdayAM» | «wednesdayAM» | «thursdayAM» | «fridayAM» | «saturdayAM» | «sundayAM» |
| AFTERNOON |  |  |  |  |  |  |  |
| 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 | |