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: | 08/12/1926 | Name: | Joan Martin | | Date: | 27/06/2024 | |
| BACKGROUND | | | | | | | |
| Who am I, summary of life history/story/interests | | | | | | | |
| About me: Joan was born in Pemberton; after leaving school she worked on the switchboard for Telecom. She met her husband, John, they married and moved to Fremantle. Joan and John have 3 children, Debbie (resides in Bunbury), Brendan (resides in Bunbury), and Kelvin (resides in Bunbury); they have 6 grandchildren, and 13 great-grandchildren. They moved to Bunbury when the children were young and have resided there ever since. After they moved to Bunbury Joan continued to work for Telecom for many years. Joan and John fostered a child, Stephen, when their children were at school; he and Kelvin were great mates. Joan and John enjoyed a holiday to America to visit their daughter-in-law's family, they've been on a couple of trips to QLD, and a cruise from Singapore back to Perth. Joan and John enjoyed regular trips to their onsite van in Dunsborough where they would catch up with friends. Sadly, John passed away in 1993. Joan purchased an onsite van in Busselton and visited with friends on a regular basis for around 10 years. Joan has lived in her current home for the past 26 years, she has a very supportive family who visit frequently and provide assistance, she also has supportive neighbours and friends who call in regularly for a cuppa. Before her health changed Joan enjoyed being part of a card group that would catch up regularly, and she was an avid reader. More recently Joan enjoys crocheting and completing the crossword puzzle in the paper every day. | | | | | | | |
| OVERALL HEALTH | | | | | | | |
| Medical History: | | | Identified Health Risks: | Mobility Support: | | | Communication Support: |
| Hypertension (high blood pressure), Pain, Bursitis (left shoulder), Urinary tract infections, Osteoarthritis, Other diseases of the skin & subcutaneous tissue n.o.s or n.e.c - skin tears and leg ulcer, Stress/urinary incontinence (includes stress, overflow, reflex & urge incontinence), Malaise & fatigue (includes general physical deterioration, lethargy and tiredness), Atrial fibrillation | | | Living alone or with an individual with similar or greater level of needs,Unlikely to be able to relocate without assistance | Independent transfers inside the home.  Standby assist transfers outside the home.  Independent ambulation inside the home.  Standby assist ambulation outside the home.  Mobility aids: Four wheeled Walker | | | Hearing impaired,Vision impaired (glasses)  Joan advised she wears glasses for watching TV. Some hearing issues and clear, direct speech is preferrable.  Wears reading glasses,Wears distance glasses  Support workers will support Joan with communication by speaking clearly and not shouting, facing Joan when speaking, reducing the distance between them and Joan, reducing background noise, rephrase the sentence as needed, checking to see that Joan 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,Enter through the unlocked door,Use the locked box to gain entry,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: |
| **Contact the emergency services (Police, Ambulance)** |
| If Southern Plus staff find me unwell and needing medical attention they should: |
| **Contact Ambulance services,Contact my emergency contacts** |
| Specific instructions for me |
| Key safe location: **Front of house**  Key safe number: **In Procura**  My emergency planning preferences (in order): **Call my mobile 0417 959 964**  **Call my landline 08 9721 2929**  **Lock box #2491**  **Call my daughter Deb 0408 912 290** |

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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 | | |
| 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:**  Joan experiences occasional STML, agitation and disorientation to time.  good understanding of her health conditions. Prefers Debbie to attend medical appointments with her to help her to hear all of the information being provided. |  | |  |  |  |
| **PERSONAL SAFETY:**  Joan has a Personal Emergency Response System (PERS) in place.  Joan does not wear her PERS pendant but hangs it on her walking frame. |  | |  |  |  |
| **PERSONAL CARE:**  Joan is not able to attend to her own foot and nail care.  Joan requires standby and physical assistance x 1 to complete her showering and to get dressed daily x 1 carer. |  | |  |  |  |
| Continence: Joan experiences urinary incontinence and uses pull-up continence aids to manage; she is linked in with the Continence Management Aids Scheme (CMAS). |  | |  |  |  |
| **MEDICATION MANAGEMENT:**  Joan can take medication independently when it's provided to her. Since attending the emergency department in April 2024 Joan is experiencing some issues with remembering when to take her medication; |  | |  |  |  |
| **NUTRITION:**  Joan advised she no longer cooks due to being unable to stand for long and experiencing fatigue.  Joan is unable to do her own shopping due to fatigue and shortness of breath on exertion.  Her family provide support with this, she can provide a shopping list. |  | | Joan's children will complete shopping general food items and supervise Joan with her meals/nutritional intake on a day to day basis. |  |  |
| **DOMESTIC ASSISTANCE:**  Joan has difficulty managing heavier tasks such as remaking/changing bed linen vacuuming, mopping, cleaning shower and toilet due to immobility from hip and foot pain. Prior to having HCP she has 1 hour per week of formal support for domestic assistance.  Prior to having a HCP Joan was having monthly formal support to assist with garden maintenance in her back yard. |  | |  |  |  |
| **FUNCTIONAL SAFETY IN THE HOME ENVIRONMENT:** |  | |  |  |  |
| **PSYCOSOCIAL SUPPORT:**  Prior to commencing on HCP Joan is having formal Social Support services for one hour per week. |  | |  |  |  |
| **TRANSPORT:**  Joan is not able to drive.  Joan is unable to access the community without assistance secondary to impaired mobility and frailty. |  | |  |  |  |
| **MAINTAINING PHYSICAL ACTIVITY & FUNCTION:**  Joan has voluntarily given up her driving license due to difficulties with mobility and getting and out of her vehicle.  Joan walks with 4 wheel walker. Joan walks slowly and with uneven gait. She experiences fatigue and shortness of breath on exertion. She requires 1 x standby assistance when in the community and does not attend the community independently.  Joan requires a low mobility appropriate vehicle in the community. |  | |  |  |  |
| **RESPITE:**  Joan has a very active and supportive family who provide regular hands on support for her. However, Joan requires frequent support with her activities of daily living which places a high demand on there own time and resources which impact on other responsibilities they have and the time they have do things for themselves. Joans, family are willing and available to continue providing support and work in partnership with Southern Cross Care to keep Joan living safely at home with the support she needs to meet her care needs. |  | |  |  |  |
| **CLINICAL CARE/**  **ALLIED HEALTH SUPPORT**  **Joan has fragile skin and experiences regular skin tears and a recurring leg ulcer.** |  | |  |  |  |

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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 |  |  |  |  |  |  |  |
| 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 | |