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: | 30/11/1933 | Name: | Helen McDonald | | Date: | 9/01/2023 | |
| BACKGROUND | | | | | | | |
| Who am I, summary of life history/story/interests | | | | | | | |
| About me: Helen was born in South Africa and then moved to New Zealand where she worked for the Salvation Army.  • She moved to Australia in May 2017 to be closer to family.  • Helen has three children, a daughter who lives in the UK, a son who lives in Brisbane and a son Andrew who lives in Busselton.  • Helen lives on a rural property in Yoongarillup, her son Andrew, daughter-in-law Lea, and family live on the same property.  Important People: • Helen’s family are very important to her.  What matters:  • It Is important for Helen to maintain her current level of independence and wellbeing.  It is important for Helen to remain living in her unit on the farm for as long as practically possible.  A good day: When Helen is feeling well she enjoys gardening, reading, completing light household tasks and walking around the property.  Helen used to enjoy walking around the farm, however her mobility has declined and she now only walks shorter distances (between the two houses and around her own garden).  A bad day: Helen has been having spells of what she (and the Dr ) term “the squirms”. She has on occasion, become unconscious and required an ambulance to be called. On-going investigations are being conducted by her GP and specialist to attempt to understand causative factors.  Helen’s health is currently unpredictable and there do not appear to be any identifiable patterns to these “seizures”. Medications are being adjusted in an attempt to lessen their occurrence.  Strenghths: Helen is able to do light gardening, reading, completing light household tasks and walking.  Helen is able to do a small shop independently in Coles.  Helen retains her cognitive function although has some mild short term memory with episodes of confusion. Helen has insight into this and recognises that this is occurring.  Generally speaking Helen is able to make decisions regarding her care and lifestyle with support with more complex matters.  Likes and dislikes: • Helen enjoys gardening, reading, completing light household tasks. | | | | | | | |
| OVERALL HEALTH | | | | | | | |
| Medical History: | | | Identified Health Risks: | Mobility Support: | | | Communication Support: |
| Lung cancer, Head & neck cancer - hemiglossectomy 2019, Left marginal mandibulectomy 2019, Deafness/hearing loss, Cataracts (surgical intervention - IOL), Macular hole right eye (surgical intervention) | | | • Helen is in remission from lung and tongue cancer, she has had surgery and completed a course of radiation. Dysarthria. Hearing impairment. | Independent transfers | | | Hearing impaired,Vision impaired (glasses)  • Helen has hearing and vision impairments.  She has bi-lateral hearing aids, however only wears one in her left ear, but still has marked hearing loss.  • Helen is able to participate in complex conversations, but does have difficulty with clear articulation due to previous tongue surgery.  • Helen is not able to communicate effectively over the phone.  Wears hearing aids,Wears distance glasses  Support workers will prompt Helen to wear her hearing aids and glasses.  Support workers will support Helen with communication by speaking clearly and not shouting, facing Helen when speaking, reducing the distance between them and Helen, reducing background noise, rephrase the sentence as needed, checking to see that Helen has understood what has been communicated.  Helen may request support workers not wear masks.  However support workers may reserve the right to wear a mask for their own protection in view of their own personal infection control requirements. |

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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;  select one or more  **Enter through the unlocked door,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:  Key safe number:  My emergency planning preferences (in order): |

| 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 |
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| **COGNITION:**  Helen is alert and orientated with a good memory - most of the time but has episodes of confusion which appear to be increasing.  Helen has capacity to make her own decisions regarding the care she receives – most of the time, however family assistance in decision making is becoming more required. | Helen will report she feels safe and secure most of the time.  Helen will have support to make decisions that involve risk |  |  |  |
| **PERSONAL SAFETY:** |  |  |  |  |
| **PERSONAL CARE:**  Helen is independent with her Personal Care – when she is well. The family have concerns that this ability is declining, particularly when Helen is unwell. Helen has times when her personal cares need supervision or assistance when she is unwell. |  |  |  |  |
|  | Continence: Prevention of increased incontinence.  Helen will maintain social continence. |  | Continence: Southern Plus will provide incontinence aids as required  Southern Plus will provide continence assessment services as and when requested by Helen/carers |  |
| **MEDICATION MANAGEMENT:**  • Helen requires supervision with her medications. |  | Helen will continue to manage and self administer her own medication in consultation with her GP and specialists with the support of Andy and Lea and family.  Helen's family (under the direction of Andy and Lea) will supervise and monitor Helen's medication administration daily to ensure she is taking correctly and prompt her as required. |  |  |
| **NUTRITION:**  • Helen eats a soft diet and normal fluids.  • Helen is able to make light snacks and drinks, she requires some assistance with chopping up vegetables  • Helen requires support when purchasing heavier items and to access the community. |  |  | Helen or her family, will request services for meal preparation and shopping assistance when required.  Southern Plus support workers will accompany Helen on her shopping trip each week (2 hour service) |  |
| **DOMESTIC ASSISTANCE:**  • Helen is able to complete some of her household tasks, requires some assistance with heavier tasks.  Self care deficit related to maintenance of safe, accessible outdoor areas and access to the home secondary to reduced activity tolerance. | Helens home environment will be maintained in a clean and tidy state.  Helens home will be accessable and safe |  | Southern Plus support workers will assist with monthly domestic assistance service to clean floors, bathroom/toilet, spot clean windows (general wipe down surfaces).  Support Helen with her DA and assist with heavier tasks. | Wellness Partner will facilitate window cleaning services through a contractor as required/requested. |
| **FUNCTIONAL SAFETY IN THE HOME ENVIRONMENT:** |  |  |  |  |
| **PSYCOSOCIAL SUPPORT:**  • Helen is socially isolated in a rural property and needs support to access the community.  • Andrews (son) and his family all work and Helen is often alone on the property for long periods of time during the day. | Helen will report that frequently engage in activities and have opportunity to build and maintain the relationships that are important to her. |  | • Southern Plus support workers will provide transport to attend activities at the Senior Citizens center on Fridays.  • Southern Plus support workers will provide transport to visit the shops and library one day a week and as required. |  |
| **TRANSPORT:** |  | Helen and Andy or Lea will assist Helen to make her appointments (hair, podiatry, medical etc) and will contact Southern Plus office to advise of transport requirements providing as much notice as possible for requirements to be met.  Helen's family will also provide transport assistance for Helen as required. |  |  |
| **MAINTAINING PHYSICAL ACTIVITY & FUNCTION:**  • At times Helen has episodes of dizziness when changing positions, ie: sitting to standing and is a falls risk.  • Helen in independent with all transfers and mobility when she is well.  • She has a 4WW which she uses when unwell. |  |  | Support workers will prompt and check Helen has taken her medication prior to leaving the house for shopping and transport services.  Support workers will monitor Helen's general condition (level of alertness and stability with mobility) prior to transport and SS services and prompt Helen to take/use her walking frame if she is feeling unsteady. |  |
| **RESPITE:** |  |  |  |  |

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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 | Monthly one hour domestic assistance |  | SS service 2 hours |  | Transport services to and from Busselton Senior Citizens - Half hour each way |  |  |
| 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 | |