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: | 26/10/1947 | Name: | Gillyee Carey | | Date: | 4/01/2024 | |
| BACKGROUND | | | | | | | |
| Who am I, summary of life history/story/interests | | | | | | | |
| About me: • Gillyee was born in Holland but has been a naturalised Australian since the age of 13.  • Gillyee and Tony have been married for over 20 years.  • Gillyee has children from her first marriage, her son Shaun and DIL Marie live locally.  • Gillyee and Tony moved back to WA from Queensland in 2017.  Important People: • Tony, her husband of 20 years, provides care and support.  • Shaun her son and DIL Marie who live locally.  What matters:  • It is important to Gillyee to remain living at home with Tony for as long as possible, maintaining as much independence as possible for as long as possible.  Strenghths: • Gillyee is able to communicate and make decisions for herself.  • She is able to complete lighter household tasks, with the support of her husband or a Support Worker.  Likes and dislikes: • Gillyee enjoys helping people.  • Enjoys and plays active role in the local theatre group. | | | | | | | |
| OVERALL HEALTH | | | | | | | |
| Medical History: | | | Identified Health Risks: | Mobility Support: | | | Communication Support: |
| Toxic effects of substances of medical source, complications of surgical & medical care...severe complications of transvaginal mesh implant surgery, Stress/urinary and faecal incontinence , Diseases of the intestine - including stomach/duodenal ulcer, abdominal hernia, diverticulitis, diarrhoea., Pain, Myocardial infarction (heart attack), Transient cerebral ischaemic attacks (T.I.A.s), Breast cancer that spread to left leg requiring operation for bone removal., Bladder cancer, Other diseases of the nervous system n.o.s or n.e.c (insomnia.) Osteoarthritis. | | | Unlikely to be able to relocate without assistance  • Gillyee’s has a number of chronic health conditions and a medical history of injury (including from cancer) that impacts on her function and is compounded by the effects of aging. | Independent transfers  Mobility aids: Four wheeled Walker,Wheel chair for longer distances | | | Gillyee is able to communicate effectively and participate in complex conversations. |

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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; |
| If Southern Plus staff are unable to gain access to my home or contact me or my emergency contact/s they are to: |
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| If Southern Plus staff find me unwell and needing medical attention they should: |
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| 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** | |  | | | |
| **Client Goal:**  **Why I have chosen this and what I hope to achieve** | |  | | | |
| **Possible Associated Risk/s of Choice or Activity** | | | **Actions/Mitigation Strategies  (The examples below can be considered/adapted, along with client specific interventions)** | | |
|  | | |  | | |
| 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:**  Gillyee experiences bouts of sadness, anger and despair related to aging, chronic health concerns and medical issues |  | | Gillyee is independently engaged with a clinical psychologist under MBS. |  |  |
| **PERSONAL SAFETY:**  Gillyee is at increased risk of medical emergency and falls and is often at home alone.  Potential for delayed access to emergency services. | Gillyee will have the ability to gain timely access to emergency services as needed. | | Gillyee will test her PERS pendant monthly to ensure it is functional.  Gillyee will wear her PERS pendant at all times. |  | Wellness Partner will arrange hire of PERS. |
| **PERSONAL CARE:**  Gillyee requires assistance to complete personal care activities secondary to the impact of aging on chronic health conditions (Osteoarthritis) |  | | Gillyee want's to continue attending to her own personal care with the support of Tony. |  | Southern Plus will support Gillyee with the provision of care aids that will assist her to be more independent with personal care as per allied health assessment and recommendation. |
| Continence: Gillyee experiences incontinence |  | |  | Continence: Southern Plus will provide incontinence assessment and incontinence aids as required. |  |
| **MEDICATION MANAGEMENT:**  Gillyee manages her own medications with the support of Tony. |  | | Gillyee has her medications placed in a medication administration device by the local chemist. Tony collects the device from the chemist. Tony reminds Gillyee to take her medications at the correct time and pops them out of the device for her. |  |  |
| **NUTRITION:**  Gillyee has a self care deficit related to meal preparation secondary to chronic health issues and age related decline | Gillyee will be adequately nourished and hydrated. | | Tony completes all the shopping.  Gillyee can prepare herself a hot drink, however Tony completes all the cooking. |  |  |
| **DOMESTIC ASSISTANCE:**  Gillyee can only lift her arms to shoulder height, therefore domestic tasks must be non-complex.  Self care deficit related to maintenance of safe, accessible outdoor areas and access to the home secondary to chronic health issues and age related decline. | Gillyees home environment will be maintained in a clean and tidy state.  Gillyees home will be accessable and safe | |  | DOMESTIC ASSISTANCE: be guided by Gillyee  - Strip and remake bed, wash sheets and hang out – as requested by Gillyee.  - Clean bathroom and toilet.  - Vacuum throughout and mop hard floors.  - Complete other OSH appropriate tasks as requested/required.  - Window cleaning Bi-annually  GARDENING:  - Gillyee has gardening completed monthly or as required by an external preferred contractor of SP.  - Has extra ad-hoc services as required to complete trimming of shrubs and seasonal tidy ups.  Provision of seasonal gutter cleaning. |  |
| **FUNCTIONAL SAFETY IN THE HOME ENVIRONMENT:**  Gillyee is at increased risk of falls and would benefit from review of her home and living spaces to assess and reduce risk factors. | Environmental risks will be reduced/mitigated. | |  |  | Wellness Partner will make a referral to TADWA for Occupation Therapy home safety assessment and facilitate provision of home modifications and equipment according to HCP inclusion/exclusion framework. |
| **PSYCOSOCIAL SUPPORT:**  Gillyee is independent with accessing the community, community groups and engaging with family and friends with the support of husband Tony. |  | |  |  |  |
| **TRANSPORT:**  Gillyee is unable to access the community without assistance secondary to impaired mobility/pain.  Gillyee requires a wheelchair taxi to access the community as she is unable to get in and out of a motor car without significant discomfort. | Gillyee will be able to access the community to attend medical and allied health appointments. | |  |  | Southern Plus will facilitate payment for wheelchair taxi services when these are not co funded by TUSS. |
| **MAINTAINING PHYSICAL ACTIVITY & FUNCTION:**  Gillyee experiences chronic pain secondary to Osteoarthritis and is only able to stand for short periods of time.  She uses mobility aids (walker and wheelchair) and has had a number of falls in the past. | Falls will be prevented.  Improvement in functional mobility and improvements in pain management. | | Tony accompanies Gillyee when going out and providing close, stand-by support for Gillyee when she wishes to access the community.  Gillyee accesses physiotherapy services through MBS and her GP Chronic Disease Management plan. |  | Gillyee requires a wheelchair to access the community.  Gillyee requires a walking frame to mobilize around her home. |
| **RESPITE:** |  | |  |  |  |
| **CLINICAL CARE/**  **ALLIED HEALTH SUPPORT** |  | |  |  |  |

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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 | |