Client Support Plan

This support plan is a summary of information gathered from the client assessment which outlines the client’s abilities, identified difficulties, sets goals and objectives. Strategies identified with the client should encourage reablement and restorative principals. Activities related to these strategies will be generated on support staff mobile devices

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| Date of Birth: | 11/03/1943 | Name: |  | Date: |  |
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| ABOUT ME | | | | | |
| Who am I, summary of life history/story: | | | | | |
| Maureen was born in England, she met her husband Patrick on a blind date, they married in 1962. Maureen and Patrick have 3 sons, Adrian (resides in Northam), Steve (resides in Australind), and Stuart (resides in Kelmscott). They have 8 grandchildren, and 2 greatgrandchildren with 1 on the way. When they moved to Australia, when Maureen was 32, they lived in Thornlie for 18 years, and Huntingdale for 18 years. Maureen was a carer at a quadriplegic centre for 10 years, and a carer in nursing homes for years - she gave up work to look after her granddaughter. Maureen and Patrick loved going on cruises, and going back to England a lot to see family. They had an 11 year old shih tzu named Tiffany who passed away 2.5 years ago; they have always had dogs, and Maureen now enjoys spending time with Steve and Sue's mixed breed dog named Shadow. Sadly, Patrick passed away 5 years ago. Maureen moved down to Australind for 1.5 years, then to Bunbury where she currently resides. Sue takes Maureen shopping twice a week, she loves to shop for clothes, and having pedicures, and her hair done regularly, and facials for a treat. She enjoys diamond dot crafts, long stitch, painting, sewing, and joining the social group at Ingenia Gardens (where she resides) for bingo, craft, and lunches. Maureen is close with her family, and stays with Sue and Steve often, she is also in regular phone contact with her twin sister, Jean, who resides in a nursing home in Cockburn. (current as at 21 December 2021) | | | | | |
| Who are important people in my life? (informal and formal supports) *i.e. relationship circle tool* | | | | | |
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| What is important to me? (wants, needs and dreams) *i.e. important to me vs important for me tool* | | | | | |
| Socialising family | | | | | |
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| ABOUT ME continued… | | | | | |
| What does a good day look like for me? | | | | | |
| Going out. No pain/arthritis. | | | | | |
| What does a bad day look like for me? | | | | | |
| Get bored sometimes. Not a lot at Ingenia. Pain arthirits - reduced mobility. | | | | | |
| My strengths are: | | | | | |
| Family, emotional and mental. | | | | | |
| My likes and dislikes are: | | | | | |
| Like: Bingo. Concerts. Painting. Crafts. | | | | | |
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| OVERALL WELLBEING | | | | | |
| General physical health *i.e. levels in independence* | | | | | |
| *Medical current: Maureen has multiple chronic health issues and mobility issues and does not drive.*  *Medical history: Asthma, Chronic Kidney Disease, Diabetes type II, Osteo Arthritis, Coronary Artery Disease - Cardiac Stent, dyslipidaemia, hypertension, low mood, episodes of loss of conciousness, Right knee and Right hip replacement, Left shoulder replacement, MVA - R leg knee injury. Cataract surgery. Hysterectomy.*  Medical support plan: Maureen sees the attending doctor at Brecken Health in Bunbury and specialist appointments as required and for clinical support for chronic health issues. Maureens family (Susan) will support her with this.  *Pain issues: Chronic and acute on chronic pain which varies between days when Maureen has no Pain to days when it is debilitating.*  Pain support plan: Maureen manages her own pain by regulating her activities and in consultation with her GP.  Recommendation: Maureen may benefit from ongoing physiotherapy for pain management. | | | | | |
| General mental health | | | | | |
| *Maureen is aware of her care needs and can communicate these.*  *Maureen is struggling with dealing with loss of loved ones, friends and function to be able to do the things that are value to her.* | | | | | |
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| GENERAL | | | | | |
| *Communication/assistive technology: Identify any special consideration* | | | | | |
| *Communication issues: Hearing and vision deficit*  Communication support plan: Support workers will utilise simple strategies to communicate with Maureen who has a hearing impairement. | | | | | |
| Mobility, balance and transfers: *Identify any specific needs*: | | | | | |
| *Mobility issues: Maureen's health conditions result in her experiencing chronic pain, mobility issues, and a fear of falling.*  *Maureen is not able to drive.*  Mobility support plan: Recommendation: regular physiotherapy to help with pain management and improve/maintain mobility reduce falls risk.  Taxi vouchers within capacity of HCP funds for client to access transport services to appointments and visit family/maintain social connections and community access. | | | | | |
| Personal Care / Showering / Bathing / Dressing | | | | | |
| *Maureen showers independently, she sits to shower using a shower stool, rails, and portable shower head.*  Maureen will continue to manage personal care independently  Southern Plus will facilitate OT self care assessment and provision of aids and services as required.  *Toileting/continence issues: Maureen experience incontinence*  Toileting/continence issues: Maureen has access to CAP funding for incontinence aids.  Maureen will attend to her own toileting and continence care needs.  Recommendation: Maureen to attend annual continence specialist reviews and continue to access CAPS funding.  *Skin integrtiy issues: Maureen bruises easily and has dry skin*  Skin integrtiy issues: Maureen manages this- dry skin managed with moisturiser. | | | | | |
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| GENERAL continued… | | | | | |
| Medication Management: *Please refer to appropriate clinical documents* | | | | | |
| *Medication support issues: Maureen reports she is able to manage her medication*  Medication support plan: Maureen wants to continue to manage her own medication. Her family provide some assistance to collect her medications from the pharmacy. | | | | | |
| Everyday activities *i.e. domestic assistance, shopping , meal preparation etc.* | | | | | |
| *Maureen requires assistance with heavier household cleanig tasks*  Southern Plus support workers will assist Maureen with cleaning her home for 1.5 hour per week  *Maureen has a self care deficit related to meal preparation secondary to activity intolerance (Shortness of breath, chronic pain)*  Southern Plus will facilitate the provision of prepared and home delivered meals through Ingenia Gardens.  Maureen will contribute to the set up, cost of the food portion of and ongoing ordering of meals. | | | | | |
| Social networks/community activities and respite | | | | | |
| *Maureen reports she feels lonely at times and needs more opportunities to engage in social activities*  WP will refer Marueen to ACAT to reciew her level of HCP funding to include enough funding to attend a centre based activity/social group  WP will assist Maureen to facilitate Center base social group under CHSP program | | | | | |
| Cognition/dementia specific requirement | | | | | |
| *Support plan factors: Maureen is aware of her care needs and can communicate these.*  *Maureen is struggling with dealing with loss of loved ones, friends and function to be able to do the things that are value to her.*  Southern Plus will facilitate referral and series of grief counselling sessions. | | | | | |

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| HOME CARE PACKAGES SERVICE GOALS OUTCOME MATRIX | | | | | | | | |
| Service Requested: | |  | | | Provider/Location: |  | | |
| Assessment Process | | | | | | | | |
| **Client Goals:**  *(What are we trying to achieve?)* | | **Long Term: Refer to “What matters.”** | | | | | | |
| **Short Term:** | | | | | | |
| **Process:**  *(How are you going to achieve it?)* | |  | | | | | | |
| **Time Frame:**  (When it is it going to be achieved?) | | Ongoing | | | | | | |
| **Monitor:**  *(Who is going to monitor the progress?)* | |  | | | | | | |
| **Outcome:**  1 Month Review | | Date: |  | | | | | |
| Comments: | | | | | | |
| **Outcome:**  2nd Review | | Date: |  | | | | | |
| Comments: | | | | | | |
| **Outcome:**  3rd Review | | Date: |  | | | | | |
| Comments: | | | | | | |

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| **Case Manager:** | | Jon Morrell | | | | | |
| **Outcome:** | |  | | | | | |
| **Ongoing / Cease:** | |  | | | | | |
| Summary of identified goals | | | | | Coordinator / Case Manager Actions | | |
| 1. Refer to support plan body | | | | | 1. | | |
| 2. | | | | | 2. | | |
| 3. | | | | | 3. | | |
| 4. | | | | | 4. | | |
| 5. | | | | | 5. | | |
|  | | | | | | | |
| Client level of involvement in the CDC budget and case management | | | | | Southern Plus/Coordinators level of involvement in budgeting and case management | | |
|  | | | | | Work in partnership with client to develop a goal orientated support plan | | |
|  | | | | | Working with schedulers to maintain appropriate services times to continue to meet clients need | | |
|  | | | | | Work with support staff to ensure quality of service delivery is maintained and Southern Plus will provide appropriate training as required | | |
|  | | | | | Manage budgets, provide invoices, monthly budget statements and report to Department of Health and Ageing | | |
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| GUIDELINES FOR SUPPORT WORKERS | | | | | | | |

* The support plan has been developed in partnership with the client as a guideline for support.
* Goals have been identified using the restorative and reablement framework. The support plan is flexible and services can be altered in consultation with the client and coordinator. The plan allows for flexibility on any given day/visit to ensure the client’s support needs are met.
* Ensure that the client is encouraged to do as much as possible for themselves thereby maintaining independence and wellbeing and supporting the client to achieve their goals.
* Use the equipment supplied to promote the clients independence.
* Use appropriate protective gear and safe equipment as identified in training.
* Provide feedback to coordinator when client has achieved any element of their goals/when support needs have changed or there is a change in the clients overall wellbeing.
* Identify and act on any factors that might lead to deterioration in independence and wellbeing of the client.
* Ensure a safe environment for the client and staff.
* Follow the organisations policies and procedures at all times.
* All Level 4 Packages will be reviewed and co-signed by an SCC Registered Nurse.

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| PARTICIPANTS INVOLVED IN DEVELOPMENT OF SUPPORT PLAN | |
| Client/Carer/Client Representative Name: | Maureen Maxwell |
| Signature: |  |
| Assessors Name: | Jon Morrell |
| Coordinator Name: | Jon Morrell |
| Clinical Nurse Name: |  |
|  | |
| This Support Plan has been discussed and agreed to with the (tick as appropriate)  Client  Representative/Carer  COPY TO BE ATTACHED TO HOME CARE AGREEMENT | |
| Client agrees to the service provider contacting their nominated emergency contact if required  Yes  No | |
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| Date of Birth: | |  | | Name: | |  | | | | Date: | 15/12/2022 2:25:00 PM | |
|  | | | | | | | | | | | | |
| INITIAL CLIENT SCHEDULE | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | Mon | | Tues | | Weds | | Thurs | Fri | Sat | | | Sun |
| Morning |  | |  | |  | |  |  |  | | |  |
| Midday |  | |  | |  | |  |  |  | | |  |
| Evening |  | |  | |  | |  |  |  | | |  |