Roshana Care Group - Macleay Valley House Nursing Home

Care Plan Report for

UR No./ACS ID: **Admission:**

Report created on: 19/09/2024 by Ashin Johnson [Clinical Nurse Specialist]

Resident Details

First Name	
Surname	
Preferred Name	
Admitted Location	
ACF ID	
D.O.B	
Admission Date	
Medicare No.	
Pension Entitlement No.	
Next of Kin	Mark
- Mobile	
Medical Practitioner's Name	
Dr's Work Phone	

Allergies

Drug Allergies	Mogadon

Risks / Safety Issues

Participating in Activities	No
Altered Behaviour Patterns	Yes
Continence Problems	Yes
Lack of insight into their own Safety	Yes
Medications that may affect safety	Yes
Impaired Mobility	Yes
Nutrition Problems	Yes
Behaviour puts Safety of others at Risk	No
Restraints used for Risk Activities	Yes
Sensory Deficits	Yes

Religion / Culture

Nationality	Australian Citizen
Religion / Belief	Uniting Church.
Level of Participation	Attends at own discretion.
Language's Spoken	English.

Relevant Medical History

Dementia	Yes
Other arthritis ie. gout, arthrosis, osteoarthritis	Yes

Other Medical Diagnosis

Hypertension,
Hypothyroidism,
Dyslipidaemia,
GORD,
Diverticulosis,
Depression,
Anxiety,
Ischaemic Colitis,
UTI,
Cholecystectomy,
Hypothyroidism,
Thyroidectomy,
Removal of hepatic cyst,
pubic rami post fall,
Past Shingles infection leaving her with Residual post Herpetic pain around rib cage,
Falls,

Hearing impairment,
Macular degeneration,
Fall with small traumatic subarachnoid haemorrhage,
Osteoarthritis in Hands, fingers and neck,
Chronic neck and left hip pain,
Shortness of breath on exertion,
Short Term memory Loss,
Lower limb oedema,
Urinary incontinence,
insomnia.
mild pharyngeal dysphagia

Summary of Preferences / Needs

Relevant Social Hx / Needs

Support needed by families / friends

Staff to spend time with engaging in conversation.
Engage family members and friends to visit.

Eating Assistance

Requires assistance in positioning self for meal	Yes
Requires meal to be cut up	Yes
Requires extensive prompting to eat/drink	Yes
Requires supervision to drink fluids	Yes

Own Teeth or Dentures

Partial Dentures	Yes
Lower Dentures	Yes
Upper Dentures	Yes
Lower Teeth	Yes

Diet Type

Diet Type	High protein/high energy high fibre diet

Diet Consistency

Main	Regular Easy to Chew
Other	regular cutup
Vegetables	Regular Easy to Chew
Other	regular cut up
Dessert	Regular Easy to Chew
Other	regular cut up

Urinary Aids

Morning aids	San 1 Premium
Afternoon aids	Nil
Night time aids	LO - Pants Premium

Hygiene Assistance

Full Assist	Yes
Dressing upper body	Yes
Dressing lower body inc, socks/shoes	Yes
Undressing	Yes
Washing body	Yes
Washing extremities	Yes
Drying body	Yes
Cleaning teeth/dentures	Yes
Make up	Yes
Hair	Yes

Toileting Assistance

Full one to one physical assistance is required to position resident on and off the toilet, commode, bedpan or urinal	Yes
Clothing adjustment after toileting	Yes
Post toilet hygiene wipe / clean peri-anal area	Yes

Potential Complications / Health Management / Medication Management Issues

Goals of Care & Interventions

Goals of Care

I want staff to prevent me from having complications. I want staff to identify the signs and symptoms of complications and manage it accordingly.

STAFF INTERVENTIONS

Deals with illness by	She gets sad
Frequency of required observations	to have monthly weighs and BP monitoring
Oral medication admin by	Care Staff - Med trained
Injectable medication admin by	Registered Nurse
Topical By	Staff

Staff interventions for oral / injectable medications

Staff place tablets one at a time onto a spoon and then tip tablets off the spoon into 's hand.
Staff provide fluids to aid swallowing and ensure safe and complete ingestion of all medications.
requires physical assistance with medications.
Staff are to stay with throughout the whole medication process, to ensure safe ingestion.
On psychotropic medications staff to monitor for any adverse effect of medications.
Notify GP with issues with medication.
GP to review medications regularly.
is Self-administering her topical cream and eyedrops.
to have a 3 monthly self-administration assessment.
Staff to ensure that medications are check regularly for

Relevant Assessment Details

Related to the following medical concerns

Related to the following medical concerns

Infection Record

Date this INFECTION was identified - DO NOT alter this date once chosen	13/09/2024
UTI - WITHOUT INDWELLING CATHETER	Yes
	Change in character of urine, New or increased burning pain on urination, frequency or urgency
Organism isolated as confirmed by Pathology	Escherichia Coli
Antibiotics/treatment used and length of time ordered for	TRIMETHOPRIM 300mg, 1 Tab Daily 14/09/2024-20/09/2024
Care Interventions	- Hydration Monitoring- To promote fluid intake - Observe for Fever, urgency, dysuria, frequency. - Regular Toileting Assistance - Implement proper Perineal care and promote Hygiene Practice
Record ID	64373792

expiration dates.
Ensure that medications are stored in the lockable drawer.

Staff Interventions for topical medications

To monitor effectiveness of the medications and to ensure to notify GP if not effective.
Ensure that eyedrops opening date is in the bottle.
Ensure to discard the eyedrops after 28 days

Immunisation History	
Details of current immunisations	11/05/2023- Fluad Quad 358950
Fluvax	11/05/2023
Tetanus	21/12/2023
COVID 19 Vaccine Date of Administration Dose 1	05/05/2021
COVID 19 Vaccine Date of Administration Dose 2	26/05/2021

Outcome of Referral

Complex Health Care Needs Summary

Complex Care Goals of Care

My clinical and medical needs will be addressed and unwanted side effects or outcomes shall be prevented.

Other Complex Care Interventions

Pain management involving therapeutic massage or application of heat packs AND frequency at least weekly AND involving at least 20 minutes of staff time in total	Yes
Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/ or chair, or cannot self ambulate. The management plan must include repositioning at least 4 times per day.	Yes

Communication / Hearing

Goals of Care

Goals

I want to have a good hearing with my hearing aids so that I can talk to anyone I like. I want to have a good conversation with everyone.

Relevant Assessment Details

Related to

Related to (Speech difficulties)	has depression and anxiety
Cognitive deficit or speech disorder affecting comprehension or speech	has depression and anxiety

Speech / Comprehension difficulties

Alert	Yes
Further Information	Occasional confusion. STML.
Slurred words	No
Single words	No

Describe Single Words

is able to communicate in full sentences without any difficulty.

Clearly spoken words	Yes
Dysphasia:	No
Dysarthria	No

Hearing details

wears a hearing aid in left ear. Aged related hearing loss.

Memory - recent / past events

Recent	has good recollection of recent events.
Past	has good recollection of the past events.

Interventions

Please note: the Language/s this person speaks is listed on the front page

Can resident use a call bell?	Yes

Call Bell Interventions

Encourage to call and wait for assistance. Ensure call bell is within easy reach especially when is in bed and when sitting on her chair. Staff to answer call bell promptly

Resident uses an emergency response aid	N/A
Interpreter required	N/A
For this language	English.

Aids to communicate

Glasses	Yes
Hearing aid	Yes
Aids worn	Yes
Repeat sentences	Yes
Use simple sentences	No
Gain eye contact before communicating	Yes

Other communication interventions

Staff to ensure reduce background noise when talking to
Gain 's attention - address by preferred name and gain eye contact.
Speak clearly and directly to - repeat if necessary.
Allow time to understand and to formulate responses.

Staff to prompt/remind to wear her eyeglasses all the time when out of bed.
Staff to ensure that is wearing her working hearing aids.

Frequency of specialist visit	Unknown

Hearing deficit

Left	Yes
Right	Yes

Hearing Deficit details

wears a hearing aid in left ear. Aged related hearing loss.

Care for hearing aid

is able to clean and fit her hearing aids. Hearing aids are stored in a hearing aid container placed in 's walker during the day and placed on top of the bedside table at night for easy access. Hearing aids battery is changed annually.

Vision Needs

Goals of Care

Goals

I want to see clearly with my eyeglasses.

Relevant Assessment Details

Related to visual changes

Macular Degeneration. Wears Bifocal eyeglasses daily.

Interventions

Glasses

Yes

Type of glasses

Bifocal blue frame eyeglasses.

When worn

wears her eyeglasses all the time during the day.

Location glasses kept

Glasses are kept in glasses case on top of bedside table

Care of glasses

is able to clean and fit her own glasses. wears glasses during the day and removes prior to bed. stores glasses in the glasses case on top of her bedside table.

Interventions to optimise vision

Staff to ensure there is adequate lighting especially during activities. Monitor 's eyes for any issues. Staff to check if glasses are clean. Ensure has regular eye checkups. Minimize clutter and furniture in 's room.Notify GP with any changes or issues with eyes or vision.

Detail strategies

Staff to remind to wear her eyeglasses especially when she is doing/joining an activity

How often

Annually

Specialist seen

EYECOAST OPTOMETRY REVIEW

Mobility & Dexterity

Goals of Care

Goals

I want to be safe when I am walking with my walker. I want to prevent myself from falling.

Reduce Pain	Yes
Increase/maintain muscle strength	Lower limbs
Maintenance/Improvement of transfers	With assistance x 1
Maintain/Improve mobility	With assistance x 1

Relevant Assessment Details

Related to	Neck Thoracic and lumbar spine
Posture	Upright
Coordination/balance	becomes unbalanced quickly due to impulsivity.
Weight bearing ability	N/A

Hand Grip

Left	weak due to arthritis both hands
Right	weak due to arthritis both hands

Interventions

Weight bearing aids used	4ww
Chair type uses during day	Normal chairs
Strategies to minimize impaired mobility issues	presents as a high falls risk;Ontario scale 30/30 Management strategies - - Electric bed, ensuring at suitable height -- Ensure appropriate footwear - Ensure room is free of clutter and hazards - Provide SBA for transfers and supervision for mobility - Ensure safe use of walking aid (4WW) throughout transfers and mobility - Ensure call bell is within reach- Regular visual checks - Regular medication review - Encourage exercises to maintain current level of function Management strategies - Regular visual checks of every hour when out of bed. Regular medication review by GP. Ensure appropriate well-fitting footwear. Ensure room is free of clutter and hazards, minimal furniture in the environment due to impaired vision. Staff to ensure that mobility aid is within reach all the time. Encourage to use call bell if requires assistance. To answer call bell promptly.

Details from Functional Assessment - assist with following

Staff to hand resident their mobility aid	Yes
Transfers (Bed to Chair assist)	Supervision - Staff to provide verbal direction
Detail to transfer	SBA with 4WW for transfers, S/V with 4WW for mobility Encourage use of 4WW at all times.
Transfer aids used	SV+4WW
Assistance to Mobilise	Supervision - Staff to provide verbal direction and/or hand resident mobility aide, fitting of prosthesis or splint if needed
Distance able to walk with physical assistance: Please provide additional instructions	SBA with 4WW for transfers, S/V with 4WW for mobility is often reluctant to seek help and

Seating preferences	Electric recliner / standard chair.	assistance and chooses
Hip Protection Required	Yes	to walk with her 4ww (sometimes even without it) around her room and along the corridor.

Other staff assistance / comments

demonstrates impulsive quick movements at times with increased instability.
Tendency to turn quickly unaware of surrounding objects or other residents presenting a falls risk and potential risk of injury.
uses a 4WW to assist with balance when mobilising.
has history of multiples falls in the past.
also has history of depression and anxiety.
prefers to mobilize herself without staff assistance.
Dignity of risk form in place to support and respect her preferences.

Other mobility aids	SV+4WW.

Detail intervention to be provided	encouraged to use her call bell at all times when she needs assistance.
Aids used in bed	SV+Bed mechanics

Potential for Injury / Risk

Goals of Care

Goals

I want to be safe from possible injuries or risks.

Relevant Assessment Details

Types of falls in past

Lost Balance	Yes
Slip	Yes
Trip	Yes

Other Types of falls in past

16/2/23 - outside of N/H required hospitalisation
3/6/23

Interventions

Type of Restraint Chemical

Continence safety issues

has a high risk of recurrent UTI.
Staff to monitor for signs of UTI such as urine color, odour, frequency, discomfort/pain during urination.
Staff to encourage to drink adequate fluids during the day.
Staff to prompt to go to the toilet during scheduled toileting regime.
To ensure that 's incontinence is managed, and that peri-anal care is attended.

Sensory deficit safety issues

is at risk of falls and injury due to poor vision and hearing, wears glasses all the time and wears hearing aids in both ears.
Staff to ensure that is wearing her glasses

Medications that may impact on Falls/Safety

Medication - generic and trade names	Seroquel 25 mg half tablet nocte
Possible adverse effects which affect safety	Drowsiness, increased risk of falls.
Record ID	38991010
Medication - generic and trade names	Venlaflaxine 100mg, Venlaflaxine 37.5 mg
Possible adverse effects which affect safety	Drowsiness, increased risk of falls.
Record ID	38991009
Medication - generic and trade names	Temzepam nocte
Possible adverse effects which affect safety	Can cause drowsiness and headache and may increase risk of falls.
Record ID	46995729

and hearing aids all the time.
Staff to ensure that 's glasses are clean and well fitting.
Staff to ensure that

's hearing aids are clean and functioning well.
Staff to reduce hazards, clutter and to minimize furniture in the environment.

Behaviour safety issues

Behaviour related safety issues

has preference of attending to her care needs herself. She is high risk of falls.
Staff to continue to encourage to call for assistance with ADL's.
To encourage to use call bell for assistance.
To supervise with ADL's if prefers to have her independence to ensure safety.
to have regular physio review of ability to perform ADL's herself to ensure safety

Lack of insight issues

is very reluctant in receiving assistant with cares, increasing her risk of falls.
Encourage to ask and wait for assistance as necessary

Psychotropic Medication Risk Review

Commencement location	In facility
Date commenced	15/08/2024
Medication name	VENLAFAXINE 75mg
Diagnosis or Indication	Depression
Date review	15/08/2024
Potential Side Effect of the Medication	Nausea headaches dizziness Insomnia Constipation

Relevant information has been provided and / or explained to the resident and / or the Substitute Decision Maker	Yes
Informed consent received from	Resident
If the resident did not give the consent, who did?	
Treating Physician Name	Dr Frank Reed

Psychotropic Medication Risk Review

Commencement location	In facility
Date commenced	16/12/2022
Medication name	TEMAZEPAM 10mg
Diagnosis or Indication	Insomnia
Date review	15/08/2024
Potential Side Effect of the Medication	Drowsiness tiredness dizziness

	headache nausea
Relevant information has been provided and / or explained to the resident and / or the Substitute Decision Maker	Yes
Informed consent received from	Resident
If the resident did not give the consent, who did?	
Treating Physician Name	Dr Frank Reed

Psychotropic Medication Risk Review

Commencement location	In facility
Date commenced	16/12/2022
Medication name	QUETIAPINE 25mg

Diagnosis or Indication	Anxiety
Date review	15/08/2024
Other Information	Anxiety related to longstanding Depression
Potential Side Effect of the Medication	Akathisia (inability to stay still) Dizziness Dystonia (involuntary muscle contractions) Headache Parkinsonism tremors Sleepiness Weight gain
Relevant information has been provided and / or explained to the resident and / or the Substitute Decision Maker	Yes

Informed consent received from	Resident
If the resident did not give the consent, who did?	
Treating Physician Name	Dr Frank Reed

Psychotropic Medication Risk Review

Commencement location	In facility
Date commenced	16/12/2022
Medication name	VENLAFAXINE 150mg
Diagnosis or Indication	Depression
Date review	15/08/2024
Potential Side Effect of the Medication	Nausea headaches dizziness Insomnia Constipation

Relevant information has been provided and / or explained to the resident and / or the Substitute Decision Maker	Yes
Informed consent received from	Resident
If the resident did not give the consent, who did?	
Treating Physician Name	Dr Frank Reed

Urinary Continence Management

Goals of Care

Goals

I would like to prevent myself from having urine infection.

Relevant Assessment Details

Type(s) of incontinence

Stress	Yes

Type(s) of incontinence

Recognizes sensation to urinate	Sometimes

Interventions

Concerns about elimination

Aids Required

Morning aids	San 1 Premium
Afternoon aids	Nil
Night time aids	LO - Pants Premium

Continence m'ment toileting times

on rising ,before /after meals,morning,afternoon tea/.tea and before going to bed at night

Times to check aids	As per scheduled toileting.

Times to prompt to toilet

Staff to prompt to go to the toilet at the scheduled toileting schedule.

Catheter use

No Devices	Yes

Care if incontinent

Assistance if incontinent

Staff to monitor for signs of UTI such as urine color, odour, frequency, discomfort/pain during urination. To encourage to drink adequate fluids during the day. To prompt to go to the toilet during scheduled toileting regime. To encourage to utilize call bell for assistance. Staff to answer call bell promptly

Care after incontinence

To ensure that incontinence is managed, and that peri-anal care is attended to. To apply skin barrier every post toileting needs. To monitor skin. To encourage to call for assistance with post toileting care.

Other care

has preferences of having her independence with her toileting care needs. goes to the toilet herself

and is not calling or asking staff assistance. has been assessed requiring assistance due to hearing and visual impairment. also has history of multiple falls and SOBOE. Dignity of risk form in place to support and respect her choices.

Bowel

Goals of Care

Goals

I want to open my bowels everyday. I do not like having constipation.

Relevant Assessment Details

Related to a lack of

Fibre	Yes

Interventions

Bowel Pattern

Constipation	Yes
Diarrhoea	Yes
Incontinence	Yes
Bowel action time of day	Mostly in the morning.
Bowel action triggers to monitor	Unknown.
Bowel Management program	

Staff to monitor & record 's bowels each shift.
Staff advise RN if bowels not open for 3 days. RN to manage constipation i.e aperients as charted.
Provide with fruit daily for breakfast.
Offer prunes/fruits during breakfast.
Encourage adequate fluid intake, offer fluids at each meal, M/Tea, A/Tea, Supper and after attending any ADLs /PAC etc & fibre in diet to help prevent constipation.
Encourage to notify RN if there is any discomfort with voiding and passing stool.
Encourage to eat food high in fibre.

Other bowel function issues to address

Other issues	has diagnosis of Diverticulosis.

Ostomy type if applicable

Toileting

Goals of Care

Goals

I want to be able to have my independence with going to the toilet.

Interventions

Details from Functional Assessment

Full one to one physical assistance is required to position resident on and off the toilet, commode, bedpan or urinal	Yes
Clothing adjustment after toileting	Yes
Post toilet hygiene wipe / clean peri-anal area	Yes
Detail intervention to be provided	

has impaired field of vision impacting on spatial perception and ability to judge – will miss toilet seat• has hearing deficit impacting on ability to hear instructions• has decreased upper limb strength and ROM with associated pain impacting on ability to push and control descent necessary to position self on/off toilet• has poor grip and dexterity with associated pain impacting on ability to grip safety rails necessary to push up and hold frame to toilet and manipulate clothing necessary to toilet• has Chronic left hip pain impacting on ability and desire to engage core muscles necessary to toilet and maintain balance• has decreased lower limb strength and ROM with associated stiffness in bilateral knees and ankles impacting on ability to push up and control descent necessary to position self on toilet. has poor balance • is falls risk with a history of falls• had impaired field of vision impacting on spatial perception and ability to coordinate movement to complete toileting activities• has decreased upper limb strength and ROM with associated pain impacting on ability to reach necessary to attend perianal hygiene• has poor grip and dexterity with associated

pain impacting on ability to grip toilet paper and adjust clothing for toilet completion• has neck and left hip pain impacting on ability and desire to engage

core muscles necessary to attend toilet completion activities and maintain balance• has decreased lower limb strength and ROM with associated pain and stiffness in bilateral knees and ankles impacting on ability to move legs necessary to attended toilet completion activities. For the above reasons requires full assistance of one nurse for all aspects of toileting and toileting completion.

Other staff assistance / comments

Staff to monitor for signs of UTI such as urine color, odour, frequency, discomfort/pain during urination. Encourage to drink adequate fluids during the day.Prompt to go to the toilet during scheduled toileting regime.Ensure that incontinence is managed, and that peri-anal care is attended to. Apply skin barrier every post toileting needs. To encourage to go to the toilet prior to settling to bed.Staff monitor & record bowel movement each shift.Staff to advise RN if bowels not open for 3 days. RN to manage constipation accordingly and to report to GP if intervention is not effective. To offer prunes during breakfast. Encourage adequate fluid intake, offer fluids at each meal, M/Tea, A/Tea, Supper and after attending any ADLs /PAC etc & fibre in diet to help prevent constipation. To encourage to notify RN if there is any discomfort with voiding and passing stool. Encourage to eat food high in fibre. has been assessed requiring assistance with toileting care needs due to hearing and vision impairment. has history of multiples falls in the past and SOBOE. also has history of depression and anxiety. However, prefers to attend to her toileting care regime on her own. Dignity of risk form in place to support and respect her preferences.

Aids used	Raised over the toilet seat
Number of staff required for toileting	x1 SB assistance

Self Care Needs - Bathing / Hygiene / Dressing Grooming

Goals of Care

Goals

I want to be presentable and clean everyday. I like to have my shower everyday.

Interventions

Prefers

Bath, Shower or Both	Shower
When	Alternate
Time AM	Morning after breakfast.

Resident staff preference for care

Others	Yes

Bathing / showering preferences / routines

Toiletries

uses palmolive shampoo and fructis conditioner for her hair. has a bar of soap for her body. uses vegesorb for her body. has olay for her face and has nivea cream as well. uses a deodorant and a powder that she applies to her chest uses a lipstick when she goes out.

Equipment / aids used	Stationary Shower chair

Haircare details

Facility hairdresser. Every 4 months to do perm, 3 monthly for hair cut.

Special Routines

like hair to be ear length.
uses a brush or comb for her hair.
has a skin moisturizer for her face and body BD.
wears pants and top and cardigan when it is cold.
wears a nightie to bed.
brushes her teeth twice a day with prompting.

Details from Functional Assessment

Needs the following assistance for hygiene

Needs full assistance	Yes
Help with undressing	Yes
Washing body	Yes
Washing extremities	Yes
Drying body	Yes
Dressing upper body	Yes
Dressing lower body	Yes
Cleaning teeth/dentures	Yes
Hair care	Yes
Make up	Yes

Detail intervention to be provided

Assist in choosing clothes. That is wearing her eyeglasses so that she can see her options of clothes. Staff to provide some assistance with undressing especially with small buttons and zippers due to decreased upper limb strength and ROM with associated pain. Staff to supervise in preparing her toiletries and setting up the water for her due to poor hand grip and dexterity with associated pain. has hearing deficit impacting on ability to hear instructions, staff to ensure to speak clearly and loudly during showers especially that is not wearing her hearing aids. Reduce background noise if required. Staff to assist in cleaning and drying other areas of body such as her lower limbs, in between toes and back. is still able to clean and dry her face, front body, and upper limbs. has been assessed requiring assistance with personal hygiene due to hearing and vision impairment. has history of multiples falls in the past and SOBOE. also has history of depression and anxiety. However, prefers to attend to

her personal hygiene on her own.Dignity of risk form in place to support and respect

her preferences.Staff to continue to encourage and remind of potential consequences of not accepting assistance being risk of falls, exacerbation of pain, impact on skin integrity.

Aids used	Stationary Shower chair

Use of anti-embolic stockings/Protective bandaging
Care staff to apply compression garments, in the form of socks/stockings, size medium to be applied to ' s bilateral legs, extending from the base of the toes to 5cm below the knee joint line. To be applied in the mornings and removed at night prior to going to bed. Compression, a minimum of 15-20mmHg, will provide graduated pressure over the lower legs and assist in the management of non-arthritic oedema in the lower limbs. The measurements, in cm, of 's legs are **circumference (R) calf: 34cm (R) ankle: 25 (L) calf: 34(L) ankle: 25 cms and length knee to heel: 47cm**

Cream details

Emollient or barrier cream	Vegiesorb.
Times to apply cream(s) within a 24 hr period:	

After morning shower/hygiene and before going to bed at night.

Laundering / Linen / Towel Preferences

Weekly linen change	Yes
Chosen day of the week	Thursday
If others, please specify	As per schedule
Facility to supply linen	Yes
No specific time to make bed	Yes
As per requested time	as per schedule.
Staff to distribute clean towels and collect dirty towels	Yes

All clothes washed by aged care service	Yes
Woolens washed by outside support	Yes
Name labels to be applied by aged care service	Yes

Oral / Dental

Goals of Care

Goals

I want to have a clean teeth and healthy mouth.

Relevant Assessment Details - refer to Teeth/Denture details in Summary of preferences

Level of Assistance

Own Teeth

Denture

State of mouth	Clean and moist
State of gums/lips	moist and pink. No cracks or lesions.
State of tongue	moist
State of teeth/dentures	

Clean full upper denture partial lower dentures. In good condition

Details re teeth as relevant	Has approx 6 lower teeth .
Tooth or mouth pain - Y/N	No
Lesions/Sores/Lumps	nil

Please refer to other Dental problems in Nutrition Needs section

Interventions

Assistance to prevent dental issues

Staff to assist with cleaning her teeth and dentures rinsing mouth and brushing her tongue, twice a day. After breakfast and before going to bed at night..

Special needs to care for teeth or dentures

Staff to assist with cleaning her teeth and dentures after breakfast and before going to bed at night.
Staff to monitor for any issues in the dentures.
Ensure dentures are well fitting.
still has her own teeth, to encourage to report any dental issues/discomfort.
Encourage to soak dentures once a week.

has been assessed requiring assistance with oral hygiene due to hearing and vision impairment.
has history of multiples falls in the past due to lack of insight and being impulsive.
also has history of depression and anxiety.
prefers to attend to her oral hygiene on her

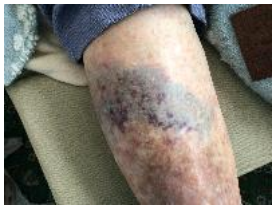
own.
Assessed to being able to attend to her oral hygiene. Dignity of risk form in place to support and respect her preferences re attending her own ADLS whilst being a high falls risk.

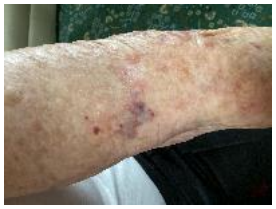
Skin / Wound

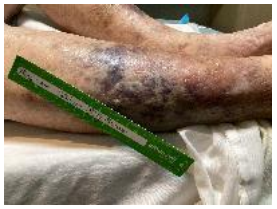
Goals of Care

Goals I want to have a healthy skin with no wounds.

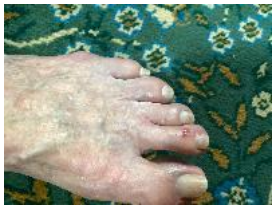
Skin Assessment Pictures

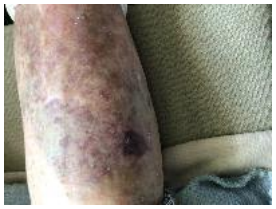

Right shin


L elbow


Right shin, lateral


Left wrist


Right toe


Rat shin

Relevant Assessment Details

Related to:

Skin/Wound Issues:

Prone to skin cancers.
uses salicylic acid for face and arms for redness.
She has poor insight into her health and safety, she prefers to attend to her care needs herself.
Risk of falls that can cause skin tears, bruises and fractures.
She has high risk of developing pressure injury.
is incontinent of urine, therefore is at risk of excoriation and IAD.
has a Diagnosis of Hypertension with associated lower limb oedema, Chronic OA, these can further impact her skin integrity.

Skin Condition:

Past/Present Conditions:

Post fall outside the N/H requiring hospitalisation 16/2/23
Entered on wound assessment on return 22/2/23
Forehead wound with x4 sutures
V shaped wound to (R) elbow with sutures

Interventions

Skin care

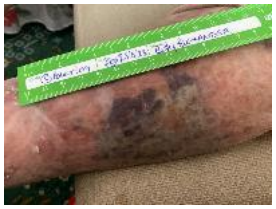
Care strategies

is high risk of developing pressure injury. Staff apply moisturiser to skin and heels twice daily and check for skin issues and report any abnormalities. Staff to monitor bony prominence's for any signs of pressure injury such as redness and skin blanching. To ensure that fingernails are short all the time. To attend to incontinence, to ensure to assist with peri-anal care. To ensure that peri-anal is clean and dried properly and to apply skin barrier to skin. Podiatrist to attend to toenails. To ensure that skin folds are clean and dried properly. To avoid rubbing motion when drying skin. To minimize clutter and furniture in the environment. Staff to encourage to mobilize when in sitting or lying position for long period of time.

Maintenance strategies

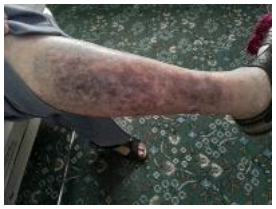
For Current Wound Management refer to Wound Care Chart. Bilateral leg oedema Anti-embolic stockings use, Care staff to apply compression garments, in the form of socks/stockings, size medium to be applied to 's bilateral legs, extending from the base of the toes to 5 cm below the knee joint line. To be applied in the mornings and removed at night prior to going to bed. Compression, a minimum of 15-20 mmHg, will provide graduated pressure over the lower legs and assist in the management of non-arthritic oedema in the lower limbs. The measurements, in cm, of 's legs are **circumference (R) calf: 34cm (R) ankle: 25 (L)calf: 34(L) ankle: 25 cms and length knee to heel: 47cm**

Pressure area care



Left shin

Wound and Skin Pictures



R) lower leg

1b skin tears (R) ring and small fingers

Dry, frail and aged skin
8/8/2022: Right forearm excision biopsy. Wound management in place. Wound healing well.
13/05/22 has bruises on her left arm, above the elbow and around the wrist. states she scratches herself. Small bruise on left shin. Doesn't remember knocking it. ? Sun spot also noted on right shoulder.
4/3/21 - Cryotherapy to multiple AKs on face, left clavicle area and upper limbs.
16/1/2023-Top to toe skin check attended. Old bruise on L/cheek which states is from her scratching herself at night and that she 'can't help' herself, and she knows her skin is fragile. She states she is not too worried about it. She pointed to multiple skin keratoses on her hands, arms, and legs, stating that her GP regularly sees her to help 'burn' them off. She is waiting for him to 'come back and cut off one of them' that is currently on the top centre of her head, which hurts if she presses it. Discolouration

Times to reposition person within a 24 hr period	Prompt to reposition every 4 hourly.
Emollient/barrier cream	Vegiesorb.

Times to apply cream(s) within a 24 hr period

After morning shower/hygiene and before going to bed at night.

Pressure relieving devices

Foam Mattress	Yes

Strategies to prevent pressure ulcers

Staff to monitor bony prominence's for any redness and blanching. Encourage to apply skin moisturizer to skin. Encourage to minimize lying and sitting in the same position for long period of time

Finger /Toe Nail problems:	Yes

Other interventions

Staff to monitor 's fingernails to ensure that they are clean and short all the time. Assist in trimming and filing fingernails.Podiatry to monitor toenails. Refer to podiatrist if required. Podiatrist to attend regularly every 6th weekly.

to bilateral shins. Old bruise on toenail of L/foot 3rd digit observed. Toenails short and clean.
21/4/23 , medical incision to right thumb and upper right arm
23/4/23 large bruise to later side of right shin15cm x 9cm
23/8/23 states she ran into another residents bed and bruised her left lower leg
2024 - Surgical wound - skin lesion removed

Systemic meds impact	Aspirin daily
Other meds impact	Sorbolene to dry skin
Bony Prominences	Yes
Bruises	Yes
Flaky / Dry Skin	Yes
Finger /Toe Nail problems	Yes
Scalp Problems	Yes
Sores	Yes

Skin Condition:

Other Skin Condition Issues:

Skin lesion/keratoses.Bilateral lower limb oedema .

Norton Score:	12

Sensory Needs

Goals of Care

Goals of Care:

Goals:	I want to maintain my sensory abilities.

Relevant Assessment Details

Related to: Seizures:	nil
Dizziness:	if she gets sick or weak
Tingling:	toes sometimes
Identifies aromas:	yes

Interventions

Details of sensory pain for staff to manage:	Funny tingling feeling in her toes sometimes
Taste Problems:	Nil currently.

Nutrition Needs

Goals of Care

Hydration Goals of Care: I want to drink adequately everyday.

Nutrition Goals of Care:

I want to be able to maintain my weight and not lose any weight. I want to eat want I want.

Relevant Assessment Details

Dental problems that may impact: None reported

Discomforts / difficulties: Has GORD and at times has discomfort eating .

Attitude to food / appetite :

has no current issues with her appetite. She prefers having medium serve of meals.

Interventions

Food Allergies

Diet type:

Please note Diabetes details on front page - if so, provide Diabetic diet and conduct Diabetes Monitoring as noted, refer to other relevant Nutrition details below

Normal	Yes
High Fibre	Yes
High Protein	Yes
Diet Type	High protein/high energy high fibre diet
Religious / Cultural dietary needs:	None mentioned.
Religious / Cultural dietary restrictions:	None mentioned.
Taste problems to monitor:	Nil currently.
Strategies to minimize nutrition safety risks:	

is at risk of loss of appetite due to GORD and abdominal pain due to diverticulitis.
Staff to avoid providing food that could trigger her GORD such as spicy food.
Staff to encourage to stay upright for 15 mins post meals and to eat food with high fibre.
To monitor for any discomfort during meal time

Food & Fluid likes/dislikes:

Food likes	Likes most foods.
Food dislikes:	Capsicum, too spicy foods, Lettuce, Asparagus .
Serve Size:	Medium
Fluid dislikes:	None mentioned

Fluid likes:

Readiness to eat related answers

Preffered Seating Location

Breakfast	Rosella Dining hall
Lunch	Main dining hall
Dinner	In her own room

Eating Aids / Utensils Details

Plate	Normal plate
Specific eating aids/utensils	Normal utensils
Cup/saucer (type other options if not shown in the list)	Cup and saucer
Special cutlery	Normal cutlery
Detail intervention to provide	

Staff to assist to cut up food.
Ensure that is eating and drinking adequately.
Offer alternative food that likes.
Ensure that avoids food that could trigger her GORD such as spicy food.
Encourage to stay upright for 15 mins post meals.
Encourage to eat food with high fibre.
Monitor for any discomfort

during meal time.

Other Staff Assistance to provide

has her breakfast and Lunch in the main dining room unless chooses to eat in room somedays.
has morning tea in the dining room in Grevillea and has dinner in room.
Staff to assist to cut up food.
Ensure that is eating and drinking adequately.
Offer alternative food that likes.
Ensure avoids food that could trigger GORD such as spicy food.
Encourage to stay upright for 15 mins post meals.
Encourage to eat food with high fibre.
Monitor for any discomfort during mealtime.

Swallowing difficulty details	Mild oropharyngeal dysphagia

Functional Assessment answers - please refer to Summary Page 2

Nutrition Risk Screening Tool Interventions - Refer to detailed NRST Assessment also

Interventions are based on risk score

.....

LOW: If score = Low Risk (1-10) repeat NRST 3 monthly or more often if obvious health changes

HIGH: If score = High Risk (20+) follow Moderate Interventions below and refer to Dietitian

MODERATE: If score = Moderate Risk (11-19) or High Risk (as above) complete following

1. Person inappropriately gained weight	No, go to Q 2
2. Person has an appetite	Yes, go to Q 3
3. Person manages larger serves of all meals	No, go to Q 4
4. Person manages double serves of desserts	No, go to Q 5

5. Level 1 interventions

6 & 7. Level 2 or Level 3 interventions

8. If High Risk - refer to Dietitian

Speech Pathology Details - interventions only show below if applicable

Oral medication administration directives

Oral medications to be crushed?	No

RN Instructions re Med Admin

Administer medications whole into s hand and will take them one at a time with a glass of fluid. RN to observe ingestion.

Tablets administered

Whole	Yes

Speech Pathology Meal Time Care Plan

Strategies for safe swallowing

Ensure alert/upright (90deg); head tilted forwards, chin towards chest (chin tuck)	Yes
Avoid distractions; concentrate on chewing, swallowing, not talking/watching tv	Yes
Ensure dentures clean and fit firmly	Yes
Clear throat whenever voice sounds 'wet/gurgly'	Yes

Eating and Drinking

Encourage to eat/ drink slowly, take small amounts, rest between mouthfuls	Yes
Encourage to chew on the stronger side of the mouth	Yes
Ensure swallows what is in mouth before next mouthful	Yes
Cough or clear throat if voice sounds 'wet', 'gurgly' or food sticking post swallow	Yes
Discontinue if patient fatigues, coughs excessively or fails to swallow	Yes
Provide oral hygiene at completion of every meal	Yes
After meal/ drink, leave person upright for the specified time (in minutes)	30mins

Other directives

Please provide soft easy to chew food with sauce added.
(unable to delete "regular cut up" under "other" on computer)

Discomfort / Pain

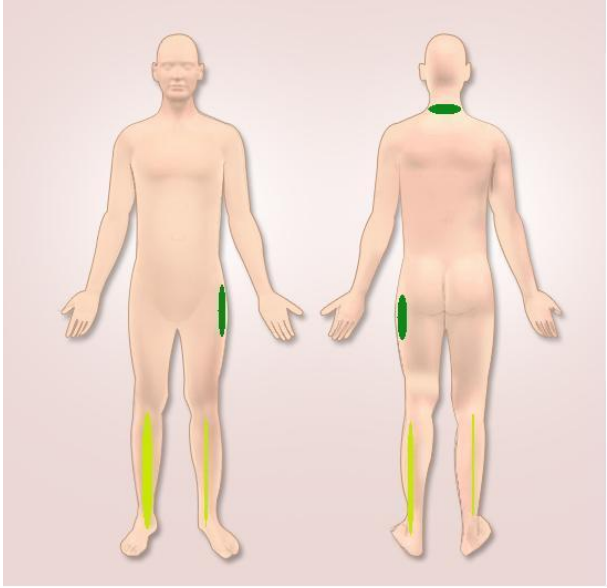
Goals of Care

Goals:

I would like for my pain to be managed and monitored by the staff. I want to be comfortable.

Relevant Assessment Details

Pain Assessment Required	Yes



Interventions

Description

Relevant medical diagnoses to consider	Ischaemic collitis Liver cyst excision, cholecystectomy, Dyslipidaemia, Diverticulosis, Depression, Anxiety, UTI, hypertension, Hypothroidism, GORD, Falls, Pelvic fracture, Hearing impairment, Fall with small traumatic subarachnoid haemorrhage
Details of Pain Scale and assessed score - i.e. Abbey Pain Scale	7
Intensity	4
Location of the pain of this intensity	Neck and L Hip area lower limbs with increasing dependent leg oedema
Details re Long-Term pain management as relevant eg. Norspan, Digesic, Morphine, Heat, Massage, TENS use	

	Ostoemol 2 tabs BD 6/10/22 Current directives (28/11/19) Carer massage/heat pack 5 minutes regularly to neck/L Hip area in combination with ADL's total 20 mins per week.
Nature of Pain	Ache, Spread Over Area, Radiating, Tight
Other	Lower limb pain is associated with increased dependent oedema
Onset	Gradual
Constant	Yes
Time most severe	In the afternoon, or after prolonged standing/sitting.
Guarding Body Part	Yes
Describe body part	Neck.
Other expression of pain	Decreased activity
Altered mood	Irritable
What causes or increases the pain that needs to be avoided?	

	to avoid sitting for prolonged periods and encourage regular gentle movement. s legs to be elevated when seated during long periods of the day.
Needs Referral	No
Pain relief Interventions including frequency of interventions	Monitor and assess level of pain regularly. Manage s pain especially at night and to notify GP if intervention is not effective. Be attentive to nonverbal cues such as frowning and guarding. Encourage seated rest breaks when has been walking for a long time and elevate her legs. Encourage to notify staff if she has discomfort and pain.
Record ID	28809417
Musculoskeletal Pain:	

Neck/thoracic spine stiffness
History of L hip/pelvic pain (previous pelvic fractures)

Sensory Pain:	Funny tingling feeling in her toes sometimes

Sleep - Rest Needs

Goals of Care

Goals: I want to have a good night sleep.

Relevant Assessment Details

Difficulties: lighting, pain, room temperature

Medical history:
Hx of Ischaemic colitis Liver cyst excision, cholecystectomy, Dyslipidaemia, Diverticulitis,Depression,Anxiety,UTI,hypertension,Hypothyroidism, GORD,Falls,Pelvic fracture,Hearing impairment,Fall with small traumatic subarachnoid haemorrhage Osteoarthritis Hands, fingers and neck Chronic neck and left hip pain Shortness of breath on exertion.Short Term memory Loss Lower limb oedema Urinary incontinence, Other Arthritis

Interventions

Usual settling time: 2230hrs

Usual rest times: occasionally naps during the day.

Usual waking time: 0600hrs

Amt Pillows: 2

Amt. blankets: 2

Sleep management plan:
Staff to monitor for pain and to manage pain prior to bed. Staff to notify GP when intervention is not effective. Staff to assist in changing into preferred night wear. Staff to administer 's night-time medication prior to bed.Staff to regularly check throughout the night. Ensure that s preferences will be done, bathroom light open with door slightly ajar, blinds closed, main door close and main lights off.Staff encourage to minimize nap time during the day to aid in sleeping at night- time. Staff to encourage to join light exercise during the day. Staff to encourage to drink warm milk of hot chocolate at night-time and to avoid caffeine

Other preferences and routines:
goes to bed around 2230hrs and wakes up at 0600hrs. has supper at 1930hrs. will brush her teeth and change into her nightie. uses 2 pillows. 1 soft and 1 hard. has 1 regular blanket and 1 knitted. likes her main lights to be off at night, bathroom light is on and bathroom door slightly ajar. Her blinds close and main door closed.

Emotional / Relationship / Intimacy / Stress Management / Spiritual - Cultural / Social - Community Needs

Goals of Care

Goals:

I will feel supported and my living / quality of life needs will be met with the assistance as stated.

Relevant Assessment Details

Frequency of family visits: weekly

Issues re family / friends relationships:

Issues to address Unknown

Feelings about relationships

sees her family and friends quite frequently and she is very happy and grateful about this.

Interventions

Religion/ Belief: Uniting Church.

Minister / church to contact: Uniting Church Minister.

Service participation: Attend when she feels inclined

Specific Spiritual needs / preferences:

Important to address

's family are the most important in her life.

Spiritual needs attends Chapel at her own discretion

Specific Cultural needs / preferences:

Cultural needs Attend Australian Cultural events

Fulfilment strategies

Staff to treat with dignity and respect.
To support and respect preferences.
To allow to take risk and to ensure that joins in activities that she prefers and enjoys.

Customs Australian Cultural Days

Support needed by resident:

Staff support strategies

Staff to spend one on one time with and discuss feelings. Encourage to open up and share her feelings to staff if she will allow it.
Staff to listen to concerns.
Staff to provide emotional support and

reassurance.

Emotional support strategies

Staff to spend one on one time and discuss 's feelings.
Encourage to open up and share her feelings to staff if she will allow it.
Staff to listen to 's concerns.
Staff to provide emotional support and reassurance.

Support relationship with:

Other important people	Family and friends.
People resident wishes to contact / confide in:	confides to her son and sister Joy

Help required:

Staff to ensure to involve 's family with any concerns or issues.

Other residents / groups the resident wishes to be in contact with:	None mentioned.

Religious/ holiday celebrations / traditions:

Other religious personnel / counselor visits / service participation when ill/dying	Minister uniting church
Celebrations	celebrates Christmas, Easter, Birthdays
Holidays	Christmas and Easter
Traditions	Australian traditions, Christmas and Easter.

Relaxation strategies:

likes reading in her room. She likes going to the cafe and having coffee with other residents. also relaxes with watching TV and her favourite shows.

Ways the person copes with difficulties:

keeps her self busy , is a very active person .

Ways to solve problems: talks to friends and staff sometimes

Assistance required:

Staff assistance

Staff to spend one on one time and discuss feelings. To encourage to open up and share her feelings to staff if she will allow it. Staff to listen to her concerns. Staff to provide emotional support and reassurance.

Other strategies

Staff to spend one on one time and discuss feelings. To encourage to open up and share her feelings to staff if she will allow it. Staff to listen to her concerns. Staff to provide emotional support and reassurance. Staff to monitor for any signs of depression and isolation.

Behaviour Management Needs

Goals of Care

Goals:

I will not demonstrate these behaviours and will feel supported as my needs are met with the assistance as stated.

Relevant Assessment Details

Issue/behaviour description	Verbal refusal of care for ADLS
Usual time of day and duration the behaviour was exhibited	During ADL's
Amount of times on average per day that behaviour was exhibited	twice
Triggers or Warning Signs	will be impulsive in her movements .
Possible contributing factor(s)	has lack of insight of her functional ability.
Successful interventions used	Provide with regular routine. Speak clearly with patience. Be calm, gentle, reassuring, supportive. Be firm but kind, refrain from arguing with Leave to settle then return and try again later
Alternate / Unsuccessful Strategies	Engage Family and Diversional therapists

Interventions

Avoid these causes of:

Stress:

If is not able to have her eye drops on time she becomes very anxious

Anger:

gets upset when she is not able to get her medications on time.

Anxiety:

Gets anxious often especially when she is not getting her medications on time.

Depression: states the feelings come and go.

Powerlessness: Not feeling in control over her medications etc

Watch for the following signs of these:

becomes quiet, holds it in .
isolates herself in her room when she is upset.

How to assist resident when upset:

How to prevent loneliness:

Encourage to attend activities.
Spend time one on one with .
Likes to read in her room.
likes to go to the cafe to socialise with other residents.

Adverse Consequences	lack of insight into her abilities which makes her a high falls risk
Related Incidents to behaviour	s impulsive behaviour and movements causes her to lose balance and fall
Effectiveness of Strategies	ongoing monitoring
Are restrictive practices required?	No
Record ID:	29165933

Behaviour demonstrated when upset:

How the person alerts staff that a problem exists

will notify staff if any concerns and then it can be followed up.
will press the call bell at times if she requires assistance.

Social Work Psychosocial Care

Relevant Assessment Details

PAS	2.0
Psychiatric Diagnosis	History of Depression, Anxiety and STML.

Geriatric Depression Scale

Cornell Depression Scale

Score / 38	22

Philadelphia Depression Scale

Other Scale

Review Psycho-Geriatrician

Psychological and Emotional Supports

Significant Life Events / Transitions / holocaust experience	Nil to note

Legal / Financial

Client Mood and Affect

Carer Mood and Affect

Client Social Adaptability

Other details re person's presentation

Client behaviour - tick as many of the following that apply

Interventions

Restraint Authorised by

Advance Directives in place

Diversional Therapy / OT / Activities Planned

Goals of Activities/Therapies

Aims of Activities

Aims

To provide with leisure activities that support her well being taking into consideration her physical, cognitive, spiritual, social and emotional needs and abilities.

Life Story Details

was born in Kempsey on 23/6/1931. is one of the 6 children. 3 of her siblings has already passed away. has 1 brother and 1 sister- Joy that are still alive. left school at the aged of 13. has completed primary level. worked for 3 years as a hospital cook at Kempsey Hospital. married her late husband Athol in 28/4/1956 and they have been together for 45 years and they were blessed of 2 children, Mark and Maree. Athol has sadly passed away in 2001. has 5 Grandchildren, Kelly, Jason, Tim, Dylan and Reece and 1 Great Grand Child. was very involved in the Gladstone Trash and Treasure Market as a caterer. has also done volunteer work for Church catering for fundraiser. enjoyed Knitting, Crocheting, and attending her local Uniting Church at Gladstone. loves to talk about her family and local news topics. loves watching her favourite TV serials such as Bold and Beautiful, Neighbors and Home and Away. also likes reading romance novels and magazines. used to have potted plants that she likes taking care of when she was at home. was a casual tennis player just doing it for fun. is afraid of snakes. likes old time music. likes all types of flowers, and her favourite color is blue

Relevant Assessment Details

Limitations / barriers observed

ambulates with aids. Osteoarthritis in Hands, fingers and neck, Chronic neck and left hip pain, lower leg oedema.

Strategies good cognitive skills

Interventions

Physical

Reason / Need to participate in activities

will be given the opportunity to maintain or improve her current level of physical fitness by attending exercise activities and walking out through the gardens on the path areas.

Activities

will be invited and supported to attend our Seated Fitness program.

Cognitive

Reason / Need for participating activities

will be given the opportunity to have her cognitive abilities maintained particularly with her love of reading.

Activities

will be invited to attend activities of a cognitive nature and ensure the Library Trolley goes to her.

Emotional / Social

Reason / Need for participating activities

will be given the opportunity to interact with other residents as she attends group activities. likes to assist other residents when she can. wishes to continue visiting other residents in their rooms to provide purpose and socializing.

Activities

will be invited and supported to dine with other residents and to attend activities such as live entertainment. Give the opportunity to assist where she can.

Creative

Reason / Need for participating activities

will be given the opportunity to be creative through a group craft activity to provide self expression and enjoyment.

Activities

will be invited to be creative by attending activities in our craft room.

Cultural

Reason / Need for participating activities

will be given the opportunity to attend activities of a cultural nature to maintain and enhance cultural needs

Activities

will be invited to attend activities of Cultural significance, such as Australia Day and Melbourne Cup Day in our main lounge room.

Sensory

Reason / Need for participating activities

will be given the opportunity to attend activities of a sensory nature to provide sensory stimulation and enjoyment

Activities

will be invited and supported to attend activities of a sensory nature such as walking outside

Task Oriented or ADL's

Reason / Need for participating activities

will be given the opportunity to attend activities related to her special interests like walks through the garden, craft group.

Activities

will be invited and supported to select activities she wishes to attend from our activities calendar.

Hobbies / Special Activities

Reason / Need for participating activities

will be given the opportunity to attend activities related to her special interests like walks through the garden, craft group.

Activities

will be supported to continue to enjoy activities that she has previously done such as the opportunity to walk out in the garden areas, and pursue her love of knitting and reading. likes to enter her craft work in the Kempsey Show

Spiritual

Reason / Need for participating activities

will be given the opportunity to attend Church services in our Chapel if she wishes.

Activities

will be invited to attend activities of a spiritual nature.

Physiotherapy - Chest/Hot/Cold/Electrical/Other - Refer to Physio Assessment AND Interventions Report also

Chest Physio

Chest Physio? No

Hot/Cold/Manual

Physio for pain m'ment

On referral/request Yes

Electrical

Massage

Area Left Big toe (Left knee)

Heat Pack

Tens

Laser

Area left big toe distal phalanx

Describe Physio discretion as an adjunct to massage

Ultrasound

Tilt Table Program

Physiotherapy - Exercise Therapy - Refer to Physio Assessment AND Interventions Report also

Exercise Therapy		Active Movem'nt Program		Exercise Programs		Splints / aids	
No. Aquatic sess'ns wkly	N/A	**No. sessions wkly**	N/A	**Individual physio exercise program**	Yes	**Splints/appliances details**	N/A

Physiotherapy - Mobility/Gait/Walking - Refer to Physio Assessment AND Interventions Report also

Mobility/Trnsfrs

Mobility aids/monitoring	4WW for mobility

Transfer Practice

Postural Correction

Gait Practice

In Parallel Bars

Walking

Walking Program

Walking Aids

AFO

Podiatry Details as applicable

Mobility - Footwear Risks

Shoes recently reviewed	Yes
Details re shoes to be used/considered	Well fitting shoes, with non slip soles.

Podiatrist footwear recommendations

Podiatrist Care Plan

Podiatrist will see this person	6-8/52 as required

Foot care

Staff to monitor and check feet. To check in between toes for any injuries. Ensure that is wearing well-fitting shoes with non slip soles

Nail Care Requirements

Staff to monitor 's fingernails to ensure that they are clean and short all the time. Assist in trimming and filing fingernails.Podiatry to monitor toenails. Refer to podiatrist if required. Podiatrist to attend regularly every 6th weekly.

Anti-embolic stockings use details

Care staff to apply compression garments, in the form of socks/stockings, size medium to be applied to ' s bilateral legs, extending from the base of the toes to 5cm below the knee joint line. To be applied in the mornings and removed at night prior to going to bed. Compression, a minimum of 15-20mmHg, will provide graduated pressure over the lower legs and assist in the management of non-arthritic oedema in the lower limbs. The measurements, in cm, of 's legs are **circumference (R) calf: 34cm (R) ankle: 25 (L) calf: 34(L) ankle: 25 cms and length knee to heel: 47cm**

Podiatrist plan - including Foot Hygiene

's Feet and toenails are washed and checked daily for infection or inflammation, fungi etc by care staff. Any abnormality is reported to the RN. Review by Podiatrist every 6-8 weeks and nails are cut and filed and cleared of sulci.

Podiatrist recommended interventions

Wash/dry between toes thoroughly, wipe with alcohol swab/other product if excessive moisture present	Yes
Check the towel for any signs of discharge after drying	Yes
Check shoes, hosiery, socks for fit and foreign objects before fitting shoes	Yes
Check shoes for wear or torn linings and excessive wear	Yes

Inspect feet from heel to toe - report joint inflammation, swelling, skin breakdown or lesions	Yes
Podiatry 6 week review	12/03/2024

Current review details

Resident seen by Podiatrist - 16/1/24
Consent obtained prior to treatment.

O/E - B/F nails long and thick, skin intact, NAD.
Treatment - B/F nails cut and filed.
Comments - Pulses palpable, skin integrity WNL, Feet and toenails are to be washed and checked daily for infection or inflammation, fungi etc by care staff. Any abnormality is reported to the RN.
Plan - review 6-8/52

Instrument sterilisation batch No. 140124

Walker
Podiatrist
AHP

Advanced Health Directives / Palliative

Goals of Care

Goals:
My needs will be addressed in accordance with my preferences.

Relevant Assessment Details

Family / Advocate discussion:	Yes
Date:	09/09/2019
Name of person/s outlining wishes:	

Medical Power of Attorney:

POA present:	Yes

Medical POA details

Name:	Mark and Maree Purcell
Relationship to person:	son
Funeral Director details:	Walkers Funeral Home

Interventions

When do family / advocate wish to be contacted:
Family can be contacted immediately in the event of sudden deterioration/death.

Religious Personnel / Counsellor visits / service participation when ill / dying: Minister uniting church

Specific wishes re care:

When Ill:
Family can be contacted immediately in the event of sudden deterioration/death.
Minister to be contacted uniting church
Allow natural death- do not try to restart heart or breathing.
Oral antibiotics for potential life threatening infection and for palliative care.
Staff to treat pain and other symptoms to keep comfortable and allow death with dignity.

When Dying:
Allow a natural death- do not try to restart heart or breathing. Oral antibiotics for potential life threatening infection and for palliative care to treat pain and other symptoms to keep comfortable and allow death with dignity.

Pain Management: to have analgesia as charted

Comfort provision:

Staff to give a left big toe and knee a massage during ADLS

Nutrition: has a regular cutup diet and thin fluids .

Medication administration details:
RN / Med assist to give medication one at a time with a glass of water and observe ingestion.

Position changes:
Staff to encourage to move and reposition as required

Skin care:
to have her limbs moisturized twice a day , once after ADLS and once before retiring

Oral care:
to have oral hygiene twice a day or PRN , staff to setup for to clean her teeth

Complementary Therapy Details