

KindCare

Individual Support and Care Plan



Individual Support and Care Plan – Jack Elliott

Plan Approval

Prepared By:	Jeremy Dyson	Position/Title:	Support Worker	Date:	6 months ago
Approved by:	Michaela Scott	Position/Title:	SW Supervisor	Date:	6 months ago
Next review date:	In two weeks				

Client and Contact Details

Client Details			
Client Name:	Jack Elliott	Date of Birth:	23/09/1927
Gender:	Male	Doctors Name:	Dr Gregory Hayes
Participants involved in care			
Name	Relationship to Client	Area of Support	
Dora Elliott	Wife	Company (24/7). Non-physical tasks	
Kathryn Thompson	Daughter	Takes to appointments	
Marg Roberts	Daughter	Takes shopping	
John Elliott	Son	Helps with home maintenance	
Happland City Council	N/A	Meals on Wheels	
Happland City Council	N/A	Cleaning (weekly)	
Emergency Contacts			
Name	Relationship to Client	Contact No.	
Kathryn Thompson	Daughter	0400 001 001	
Marg Roberts	Daughter	0400 002 002	
Care Alerts (e.g. Falls Risk, Allergies, Diabetic)			
Falls Risk: Moderate Mild dementia – see notes under behaviour Diabetic			

Medication

Current Medication

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Name	Type (tablet, liquid)	Dosage	Frequency
Warfarin	Tablet	1 Tablet	Once a day
Insulin	Injection	10mls	3 times per day before eating
Medication			
<input checked="" type="checkbox"/> Prepacked		<input type="checkbox"/> Measure	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully assist Do injections	<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> Prompt Warfarin Tablet
Specialised Care Plans			
Please see Specialised Care Plans (if ticked) for:			
<input type="checkbox"/> Pain Management	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Restraint	<input type="checkbox"/> Physiotherapy

Mobility

Movement				
<input type="checkbox"/> Able to walk unassisted	<input type="checkbox"/> Quad stick	<input checked="" type="checkbox"/> Electric wheelchair		
<input type="checkbox"/> Walking stick	<input checked="" type="checkbox"/> Walking frame	<input type="checkbox"/> Manual wheelchair		
Care needs:				
Maintain both. Set up frame each morning for use around the house. Only uses wheelchair on outings.				
Transfers				
<input checked="" type="checkbox"/> Independent weight bearing	<input type="checkbox"/> Hoist	<input type="checkbox"/> One staff assist		
<input type="checkbox"/> Non-independent weight bearing	<input type="checkbox"/> Standing hoist	<input type="checkbox"/> Two staff assist		
<input type="checkbox"/> Slide sheet	<input type="checkbox"/> Other _____			
Care needs:				
Position chair/walker for ease of transfer				

Vision and Hearing

Vision	
<input checked="" type="checkbox"/> Wears glasses full time	<input type="checkbox"/> Wears contact lenses (multiple days)
<input type="checkbox"/> Uses reading glasses only	<input type="checkbox"/> Wears contact lenses (daily)
<input type="checkbox"/> Vision impaired: Level of impairment _____	
<input type="checkbox"/> White walking cane	<input type="checkbox"/> Guide dog (Name: _____)

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Care needs:	
Clean glasses daily Check fit	
Care goals:	
Maintain vision	
Hearing	
<input checked="" type="checkbox"/> Hearing aid (right ear)	<input checked="" type="checkbox"/> Hearing aid (left ear)
<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> No aids
Care needs:	
Help to put in after shower Check settings	
Care goals:	
Maintain hearing level	

Language and Speech

First Language Spoken	English
Second Language Spoken	Nil
Speech disorders (e.g. stuttering, slurring, etc.)	Nil

Toileting and Continence

Bladder Continence	
<input checked="" type="checkbox"/> Continent	<input type="checkbox"/> Total incontinence
<input type="checkbox"/> Partial/occasional incontinence	<input type="checkbox"/> Catheter
Bowel Continence	
<input checked="" type="checkbox"/> Continent	<input type="checkbox"/> Total incontinence
<input type="checkbox"/> Partial/occasional incontinence	<input type="checkbox"/> Colostomy bag
<input type="checkbox"/> Diarrhoea (Frequency _____)	<input checked="" type="checkbox"/> Constipation (Frequency: <u>when inactive</u>)
Bowel Management	
<input checked="" type="checkbox"/> High fibre diet	<input type="checkbox"/> Oral laxatives (Brand/dose _____)

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<input type="checkbox"/> Other: _____	
Continence Aids	
<input type="checkbox"/> Commode	<input type="checkbox"/> Urodome
<input checked="" type="checkbox"/> Over toilet frame	<input type="checkbox"/> Bed pan
Toileting Needs	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	
Care goals:	
Maintain continence and reduce episodes of constipation	

Showering and Grooming

Showering	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>Preheat bathroom</u>	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Shower <u>When unsteady</u>	<input type="checkbox"/> Bath
<input checked="" type="checkbox"/> Wash hair in shower (Frequency <u>twice per week</u>)	
<input type="checkbox"/> Bed sponge bath (Frequency _____)	
Showering Aids	
<input checked="" type="checkbox"/> Shower Chair	<input type="checkbox"/> Other _____)
Toiletries	
<input checked="" type="checkbox"/> Regular soap	<input type="checkbox"/> Aqueous cream
<input checked="" type="checkbox"/> Deodorant/antiperspirant	<input type="checkbox"/> Moisturiser <input type="checkbox"/> AM <input type="checkbox"/> PM
Grooming	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Wet shave	<input checked="" type="checkbox"/> Electric shave
Teeth	
<input type="checkbox"/> Own teeth	<input checked="" type="checkbox"/> Dentures
<input type="checkbox"/> Partial denture	<input type="checkbox"/> None
Own Teeth/Denture care	

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<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> Prompt <u>Overnight soak in Polident</u>
Hand and Fingernail Care	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist <u>clip nails weekly</u>
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Foot and Toenail Care	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist <u>clip nails weekly</u>
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Podiatrist (Frequency _____)	
Dressing and Undressing	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>sometimes requires assistance with shoes</u>	<input type="checkbox"/> Prompt
Dressing Assistance	
<input checked="" type="checkbox"/> Clothing selection	<input type="checkbox"/> Underwear
<input type="checkbox"/> Bra	<input type="checkbox"/> Belt
<input type="checkbox"/> Buttons	<input type="checkbox"/> Zips
<input type="checkbox"/> Stockings	<input type="checkbox"/> Socks
<input type="checkbox"/> Make up	<input type="checkbox"/> Jewellery
<input checked="" type="checkbox"/> Shoes	<input type="checkbox"/> Other: _____
Care goals:	
Maintain current level of independence	

Eating and Drinking

Meal Preparation	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist <u>Does not cook but gets Meals on Wheels (dinner)</u>
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Type of Diet	
<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Soft
<input type="checkbox"/> Minced	<input type="checkbox"/> Pureed
Eating	

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<input checked="" type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>may need help to cut food</u>	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Right handed	<input type="checkbox"/> Left handed
Preferred place to eat	
<input checked="" type="checkbox"/> Kitchen or dining table	<input type="checkbox"/> Lounge room
<input type="checkbox"/> Tray table	<input type="checkbox"/> Other: _____
Eating Aids	
<input type="checkbox"/> Modified cutlery	<input type="checkbox"/> Modified crockery
<input type="checkbox"/> Bowl	<input checked="" type="checkbox"/> Clothing protector <u>napkin</u>
<input type="checkbox"/> Other: _____	
Drinking	
<input checked="" type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> Prompt <u>Forgets to drink water</u>
Drinking Aids	
<input type="checkbox"/> Modified cup	<input type="checkbox"/> Straw
<input type="checkbox"/> Clothing protector	<input type="checkbox"/> Other: _____

Domestic Needs

Cleaning	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Other: _____ has weekly cleaner	
Meal Preparation and Cooking	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Other: _____ has Meals on Wheels and wife cooks	
Shopping	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Other: _____ daughter takes shopping	
Laundry	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist

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<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Other: <u>wife does laundry</u>	

Social and Emotional Needs

Religion/Spirituality	
Religion/Beliefs:	<u>Roman Catholic</u>
Place of Worship:	<u>St Marys – 12 Ripon Street Happland</u>
Day, time, to attend:	<u>Sundays, 10am, and any holidays (e.g. Good Friday)</u>
Pastoral Care Requirements	
Nil	
Pets	
Pet Type and Name	
Nil	
Pet Care Needs	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Employment Details	
Company:	Nil
Manager/Supervisor Name:	Nil
Address:	Nil
Contact No:	Nil
Work days and hours:	Nil
Transport to/from work:	Nil
Hobbies and Social Activities	
Hobbies/Interests/Sports/Sporting Teams	
Gardening	
Social or Community Groups	
RSL Senior Citizens Club	
Preferred Social Outings	

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Bingo

Preferred Activities

Gardening, movies, DVDs

Behaviour

Main Concerns

Mild Dementia

Can be very forgetful some days and this causes him stress, frustration and confusion. When this happens he has difficulty finding his words and can be quite teary. Jack can occasionally become agitated.

Care Needs

Provide prompts gently; change the subject until he calms. Allow his privacy. Reassure him.

Care Goals

Support and calm

Other

Other Relevant Information

Army veteran – loves to share his stories
Loves his garden – was a farmer
Occasional smoker
Occasional drinker