

KindCare

Individual Support and Care Plan



Individual Support and Care Plan - Zhi (Helen) Chou

Plan Approval

Prepared By:	Leah Wallace	Position/Title:	Support Worker	Date:	1 year ago
Approved by:	Michaela Scott	Position/Title:	SW Supervisor	Date:	1 year ago
Next review date:	2 weeks from now				

Client and Contact Details

Client Details					
Client Name:	Zhi (Helen) Chou*	Date of Birth:	11/3/1987		
Gender:	Female	Doctors Name:	Dr Gabor Machala		
ID:	DIS00378263				
Participants involved in care					
Name	Relationship to Client	Area of Support			
Charlie Zhen	Brother	Takes her to family events and does home maintenance			
Tilly Zhen	Sister	Takes her to social activities (dances) and shopping (weekly)			
Emergency Contacts					
Name	Relationship to Client	Contact No.			
Walter Chou	Brother	0400 005 005			
Cherry Chou	Sister	0400 006 006			
Care Alerts (e.g. Falls Risk, Allergies, Diabetic)					
Risk of falls – high Has Cerebral Palsy					

**Notes: Goes by Helen*

Medication

Current Medication			
Name	Type (tablet, liquid)	Dosage	Frequency
Diazepam	Tablet	1 Tablet	Twice daily (morning and evening)
Medication			
<input checked="" type="checkbox"/> Prepacked		<input type="checkbox"/> Measure	

KindCare

Individual Support and Care Plan



<input type="checkbox"/> Independent	<input type="checkbox"/> Fully assist	<input checked="" type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
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 type="checkbox"/> Electric wheelchair
<input checked="" type="checkbox"/> Walking stick	<input type="checkbox"/> Walking frame	<input type="checkbox"/> Manual wheelchair
Care needs:		
Need walking stick set out before getting out of bed		
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:		
May need assistance with transfers occasionally		

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: _____)
Care needs:	
Clean for her daily	
Care goals:	
To maintain current level of vision	
Hearing	

KindCare

Individual Support and Care Plan



<input type="checkbox"/> Hearing aid (right ear)	<input type="checkbox"/> Hearing aid (left ear)
<input type="checkbox"/> Cochlear implant	<input checked="" type="checkbox"/> No aids
Care needs:	
Nil	
Care goals:	
To maintain current level of hearing	

Language and Speech

First Language Spoken	Mandarin
Second Language Spoken	English (fluent; occasionally unsure of colloquialisms)
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 type="checkbox"/> Constipation (Frequency: <u>when inactive</u>)
Bowel Management	
<input type="checkbox"/> High fibre diet	<input type="checkbox"/> Oral laxatives (Brand/dose _____)
<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 checked="" type="checkbox"/> Supervise <u>may require assistance at times</u>	<input type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	

KindCare

Individual Support and Care Plan



Care goals:

To maintain current levels of continence and independence

Showering and Grooming

Showering	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>run water, may require assistance entering shower at times</u>	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Shower	<input type="checkbox"/> Bath
<input checked="" type="checkbox"/> Wash hair in shower (Frequency _____ every second day _____)	
<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 checked="" type="checkbox"/> Moisturiser <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM
Grooming	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>goal to be independent may require some assistance at times</u>	<input type="checkbox"/> Prompt
<input type="checkbox"/> Wet shave	<input type="checkbox"/> Electric shave
Teeth	
<input checked="" type="checkbox"/> Own teeth	<input type="checkbox"/> Dentures
<input type="checkbox"/> Partial denture	<input type="checkbox"/> None
Own Teeth/Denture care	
<input checked="" type="checkbox"/> Independent <u>goal to be independent may require some assistance at times</u>	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Hand and Fingernail Care	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Foot and Toenail Care	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist

KindCare

Individual Support and Care Plan



<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Podiatrist (Frequency _____)	
Dressing and Undressing	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
Dressing Assistance	
<input type="checkbox"/> Clothing selection	<input checked="" type="checkbox"/> Underwear
<input checked="" type="checkbox"/> Bra	<input type="checkbox"/> Belt
<input checked="" type="checkbox"/> Buttons	<input checked="" type="checkbox"/> Zips
<input checked="" type="checkbox"/> Stockings	<input checked="" type="checkbox"/> Socks
<input checked="" type="checkbox"/> Make up	<input checked="" type="checkbox"/> Jewellery
<input checked="" type="checkbox"/> Shoes	<input type="checkbox"/> Other: _____
Care goals:	
To maintain currently level of assistance	

Eating and Drinking

Meal Preparation	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist
<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	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>goal to be independent but will generally require some assistance</u>	<input type="checkbox"/> Prompt
<input type="checkbox"/> Right handed	<input checked="" 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>

KindCare

Individual Support and Care Plan



<input type="checkbox"/> Other: _____	
Drinking	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise <u>goal to be independent but will generally require some assistance</u>	<input type="checkbox"/> Prompt
Drinking Aids	
<input type="checkbox"/> Modified cup	<input checked="" type="checkbox"/> Straw
<input type="checkbox"/> Clothing protector	<input type="checkbox"/> Other: _____

Domestic Needs

Cleaning	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	
Meal Preparation and Cooking	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	
Shopping	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> Other: <u>sister takes her shopping weekly</u>	
Laundry	
<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Fully Assist <u>weekly</u>
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	

Social and Emotional Needs

Religion/Spirituality	
Religion/Beliefs:	Taoist
Place of Worship:	Nil
Day, time, to attend:	Nil

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Individual Support and Care Plan



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	
Walks, old movies, and book club	
Social or Community Groups	
Book club	
Preferred Social Outings	
Book club (Tuesdays and Thursdays) Black and white films; drive-in movies	
Preferred Activities	
Reading; watching old films; walks in the garden (requires assistance)	

Behaviour

Main Concerns
Typically calm, positive and upbeat
Care Needs

KindCare

Individual Support and Care Plan



Ask for updates on her latest readings or movie watching.

Care Goals

Maintain current mood and behaviour

Other

Other Relevant Information

Helen has difficulty with standing for long periods, walking and fine motor skills. She tries to be as independent as possible and appreciates the opportunity to try things by herself before assistance is provided.

Helen's sister calls regularly, takes her to book club and shopping. Her brother picks her up for family events (usually every month or so) where she sees other family.