

# KindCare

## Individual Support and Care Plan



### Plan Approval

<b>Prepared By:</b>	Leah Wallace	<b>Position/Title:</b>	Support Worker	<b>Date:</b>	8 months ago
<b>Approved by:</b>	Michaela Scott	<b>Position/Title:</b>	SW Supervisor	<b>Date:</b>	8 months ago
<b>Next review date:</b>	In two weeks				

### Client and Contact Details

Client Details			
<b>Client Name:</b>	Christina Scott	<b>Date of Birth:</b>	18/9/1991
<b>Gender:</b>	Female	<b>Doctors Name:</b>	Dr Kimberly West
<b>ID:</b>	DIS00374497		
Participants involved in care			
<b>Name</b>	<b>Relationship to Client</b>	<b>Area of Support</b>	
Natalie Scott	Mother	Takes shopping, to doctors and church weekly	
Joshua Scott	Father	Assists with home maintenance	
Dr Kimberly West	Doctor	General health	
Emergency Contacts			
<b>Name</b>	<b>Relationship to Client</b>	<b>Contact No.</b>	
Natalie Scott	Mother	0400 006 006	
Joshua Scott	Father	0400 007 007	
<b>Care Alerts (e.g. Falls Risk, Allergies, Diabetic)</b>			
Intellectual disability (development age; 12 years old)			

### Medication

Current Medication			
<b>Name</b>	<b>Type (tablet, liquid)</b>	<b>Dosage</b>	<b>Frequency</b>
Naproxen	Tablet	2 Tablets	When in pain
Medication			
<input checked="" type="checkbox"/> <b>Prepacked</b>		<input type="checkbox"/> <b>Measure</b>	
<input type="checkbox"/> <b>Independent</b>	<input type="checkbox"/> <b>Fully assist</b>	<input checked="" type="checkbox"/> <b>Supervise</b>	<input type="checkbox"/> <b>Prompt</b>
Specialised Care Plans			
<b>Please see Specialised Care Plans (if ticked) for:</b>			
<input checked="" type="checkbox"/> <b>Pain Management</b>	<input type="checkbox"/> <b>Wound Care</b>	<input type="checkbox"/> <b>Restraint</b>	<input type="checkbox"/> <b>Physiotherapy</b>

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### Mobility

<b>Movement</b>		
<input checked="" type="checkbox"/> Able to walk unassisted	<input type="checkbox"/> Quad stick	<input type="checkbox"/> Electric wheelchair
<input type="checkbox"/> Walking stick	<input type="checkbox"/> Walking frame	<input type="checkbox"/> Manual wheelchair
<b>Care needs:</b>		
<b>Transfers</b>		
<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 _____	
<b>Care needs:</b>		

### Vision and Hearing

<b>Vision</b>	
<input 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: _____)
<b>Care needs:</b>	
Nil	
<b>Care goals:</b>	
Maintain current level of vision	
<b>Hearing</b>	
<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
<b>Care needs:</b>	
Nil	
<b>Care goals:</b>	

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Maintain current level of hearing

### Language and Speech

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

### Toileting and Continence

<b>Bladder Continence</b>	
<input checked="" type="checkbox"/> Continent	<input type="checkbox"/> Total incontinence
<input type="checkbox"/> Partial/occasional incontinence	<input type="checkbox"/> Catheter
<b>Bowel Continence</b>	
<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> )
<b>Bowel Management</b>	
<input type="checkbox"/> High fibre diet	<input type="checkbox"/> Oral laxatives (Brand/dose _____)
<input type="checkbox"/> Other: _____	
<b>Continence Aids</b>	
<input type="checkbox"/> Commode	<input type="checkbox"/> Urodome
<input type="checkbox"/> Over toilet frame	<input type="checkbox"/> Bed pan
<b>Toileting Needs</b>	
<input checked="" type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Other: _____	
<b>Care goals:</b>	
Maintain current level of continence and independence	

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### Showering and Grooming

<b>Showering</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> <b>Prompt</b>
<input type="checkbox"/> Shower	<input type="checkbox"/> Bath
<input checked="" type="checkbox"/> <b>Wash hair in shower</b> (Frequency <u>every second day</u> )	
<input type="checkbox"/> Bed sponge bath (Frequency <u>                    </u> )	
<b>Showering Aids</b>	
<input type="checkbox"/> Shower Chair	<input type="checkbox"/> Other <u>                    </u> )
<b>Toiletries</b>	
<input checked="" type="checkbox"/> <b>Regular soap</b>	<input type="checkbox"/> Aqueous cream
<input checked="" type="checkbox"/> <b>Deodorant/antiperspirant</b>	<input type="checkbox"/> Moisturiser <input type="checkbox"/> AM <input type="checkbox"/> PM
<b>Grooming</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> <b>Prompt</b>
<input type="checkbox"/> Wet shave	<input type="checkbox"/> Electric shave
<b>Teeth</b>	
<input checked="" type="checkbox"/> <b>Own teeth</b>	<input type="checkbox"/> Dentures
<input type="checkbox"/> Partial denture	<input type="checkbox"/> None
<b>Own Teeth/Denture care</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> <b>Prompt</b>
<b>Hand and Fingernail Care</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> <b>Supervise</b>	<input type="checkbox"/> Prompt
<b>Foot and Toenail Care</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input checked="" type="checkbox"/> <b>Podiatrist</b> (Frequency <u>                    </u> )	
<b>Dressing and Undressing</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input checked="" type="checkbox"/> <b>Prompt</b>
<b>Dressing Assistance</b>	

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<input 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 type="checkbox"/> Shoes	<input type="checkbox"/> Other: _____
<b>Care goals:</b>	
Maintain current level of independence	

### Eating and Drinking

<b>Meal Preparation</b>	
<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input checked="" type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<b>Type of Diet</b>	
<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Soft
<input type="checkbox"/> Minced	<input type="checkbox"/> Pureed
<b>Eating</b>	
<input checked="" type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<input type="checkbox"/> Right handed	<input type="checkbox"/> Left handed
<b>Preferred place to eat</b>	
<input checked="" type="checkbox"/> Kitchen or dining table	<input type="checkbox"/> Lounge room
<input type="checkbox"/> Tray table	<input type="checkbox"/> Other: _____
<b>Eating Aids</b>	
<input type="checkbox"/> Modified cutlery	<input type="checkbox"/> Modified crockery
<input type="checkbox"/> Bowl	<input type="checkbox"/> Clothing protector
<input type="checkbox"/> Other: _____	
<b>Drinking</b>	
<input checked="" type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<b>Drinking Aids</b>	
<input type="checkbox"/> Modified cup	<input type="checkbox"/> Straw

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<input type="checkbox"/> Clothing protector	<input type="checkbox"/> Other: _____
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### Domestic Needs

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

### Social and Emotional Needs

<b>Religion/Spirituality</b>	
Religion/Beliefs:	Catholic
Place of Worship:	St John's
Day, time, to attend:	Sunday 8am
<b>Pastoral Care Requirements</b>	
Nil	
<b>Pets</b>	
<b>Pet Type and Name</b>	
Nil	
<b>Pet Care Needs</b>	

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<input type="checkbox"/> Independent	<input type="checkbox"/> Fully Assist
<input type="checkbox"/> Supervise	<input type="checkbox"/> Prompt
<b>Employment Details</b>	
Company:	Nil
Manager/Supervisor Name:	Nil
Address:	Nil
Contact No:	Nil
Work days and hours:	Nil
Transport to/from work:	Nil
<b>Hobbies and Social Activities</b>	
<b>Hobbies/Interests/Sports/Sporting Teams</b>	
Reading, movies, church, and painting.	
<b>Social or Community Groups</b>	
Arts group (Wednesdays), St Johns Church	
<b>Preferred Social Outings</b>	
Church events, Movies, Art galleries (when able)	
<b>Preferred Activities</b>	
Reading (does not like to be read to), movies, painting	

### Behaviour

<b>Main Concerns</b>
Very positive and relaxed. Christina has an intellectual disability (development age; 12 years old).
<b>Care Needs</b>
Assist her with reading (Christina has the functional literacy to complete simple tasks but has difficulty with reading in new contexts or at above an approximate Grade 3 level).
<b>Care Goals</b>
To maintain current mood.

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### Other

Other Relevant Information
<p>Christina is fairly quiet and prefers minimal conversation most days.</p> <p>Natalie (mother) helps Christina prepare a shopping list, shop and put away groceries. Also picks up for her monthly doctor's appointments.</p> <p>Natalie and Joshua (father) pick up Christina and take her to church and lunch on Sundays and to her Arts group on Wednesdays.</p>