XC200920

Augusta Health Service

Resident Care Plan

(Residential Aged Care)

Doctor: Louise Marsh

Room: 4A

Surname JOHNSON		UMRN / MRN M2435498
Given Name RON	DOB 9/1/1954	Gender M
Address 5555 DONOVAN ST, AUGUSTA, WA		Post Code 6290
	Telephone 08 9758 1227	

Allergies / Sensitivities / Clinical Alerts: NIL

- Complete Care Plan using information obtained from the assessments
- Commence a Specific Care Plan (RC 6), if the information to guide staff cannot be explained on this form, if there are complex care needs and for any challenging or high risk behaviours that the resident exhibits.

This resident has a specific care plan for:

Date	Care Issue (Specific Care Plan)	Date Ceased
/ /		/ /
/ /		/ /
/ /		/ /
/ /		/ /
/ /		/ /
/ /		/ /

MY CARE NEEDS

Communication Barriers

Understands English?	☒ Yes ☐ No ☐ Limited	Language spoken:
Interpreter required	☐ Yes ☒ No	Usual interpreter:
Dysarthria / Dysphasia	☐ Refer to Speech Pathologist	

Visual / Hearing Aids Complete Specific Care Plan RC 6 if further detail required

Glasses	☒ No ☐ Yes ☐ Distance ☐ Reading		☐ Worn ☐ Marked with resident name
Contact lens	☒ No ☐ Yes ☐ Cleaned by staff		☐ Resident prompted
Hearing Aids	☒ No ☐ Yes ☐ Left ear ☐ Right ear		☐ Put in by staff ☐ Marked with resident name
	Battery change:	☐ Resident ☐ Staff	☐ Resident with assistance ☐ Family
	Cleaning:	☐ Resident ☐ Staff	☐ Resident with assistance ☐ Family

My Current Mobility / Disability Requirements: Specify aids and devices, bariatric requirements

☒ Complete FRAMP (MR 521) Date completed: ☒ Refer to Physio / OT

☒ **Identified falls risk** ☒ Falls intervention strategies implemented: 02/09/YY

My bed and transfer – staff assist requirements are: ☒ Independent ☐ 1 ☐ 2 ☐ Other:

I need a transfer device: ☐ Hoist ☐ Standing Hoist ☐ Re-Turn ☐ Slide-sheet ☐ Wheelchair ☐ Other

My positioning and seating requirements are:

Remind me to change position regularly

My mobility aids are:

Four-wheeled walker

My exercise program is: See Specific Care Plan (RC 6)

Balance	Sitting:	☐ Dependent	☒ Independent	☐ Variable
	Standing:	☐ Dependent	☐ Independent	☒ Variable

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My Comfort / Pain / Sleep Management

Complete: ☒ Pain Assessment (RC9) and ☒ Evaluation (RC10) ☒ Sleep Assessment (RC21)

Analgesics ☒ Yes ☐ No ☐ Regular ☒ PRN Sedation ☐ Yes ☒ No

☐ Independent to take medications ☐ Self-medicating (Complete RC 26)

☒ Dosage administration aids ☐ Assistance needed (Complete Medication Plan)

My pain management plan: Offer heat pack first and then if still pain after 15 minutes offer analgesia.

My settling routine / rituals:

☒ Hot Packs ☐ Cold Packs ☐ Splints ☐ Supports ☐ Other:

My positioning strategies / preferences:

Preferred bed-time: 20:00 ☐ Day-time rest: 11:00 ☐ Chair ☒ Bed

My Nutrition / Elimination / Hygiene / Personal Care:

Complete ☒ Dietary Preference (RC 15)

Complete Referral/s (if required) ☒ Podiatry ☐ Speech Pathology ☐ Dietitian ☐ OT

Additional charts in use: ☐ Fluid Balance Chart (MR144) ☒ Bowel Chart (RC 12)

☐ Food Allergy / intolerance: NIL _____

☒ Independent with meals ☐ Assistance with meals ☐ Needs positioning for meals

☐ Modified crockery (lipped plate) ☐ Modified cutlery (angled spoon) ☐ Beaker

☐ Other:

Swallowing difficulty ☐ Yes ☒ No Swallowing Assessment completed Date:

☐ My strategies for safe eating (e.g. spoon placed at back of mouth, left head turn for swallow, high back chair etc.)

Special diet: see RC 15 _____

Dietary supplements: _____

Weigh: ☒ Monthly ☐ Fortnightly ☐ Weekly (day):

Personal Hygiene

☐ Assistance with showers ☐ Yes ☐ No Person assist ☐ 2 person assist ☐ Trolley ☐ Shower chair

☒ **Shower** (circle): (M) T (W) Th (F) S (Sun) ☒ **Wash / sponge** (circle) M (T) W (Th) F (S) Sun

☐ Normal soap ☒ Aqueous ☐ Other (specify): _____

Staff assist with: ☒ Set / adjust water temp ☐ Washing ☒ Drying

☐ Emollient cream Type: _____ ☐ Skin fold care: ☐ am ☐ pm

Clean teeth / dentures: ☐ am ☐ pm ☐ Remove at night ☐ Mouth care after meals

Shave: Day: Everyday

Clean / cut fingernails: Day: Sundays Podiatry: ☒ Yes ☐ No

Hair wash: Day: Mon & Fri Hairdresser: ☒ Yes ☐ No Frequency: Monthly

Dressing / Grooming

☒ Independent ☐ Supervision / prompt ☐ I person assist ☐ 2 person assist

Staff assist with:

☐ Selecting clothes ☐ Dressing ☐ Undressing ☐ Jewellery

☐ Make-up ☐ Brush hair ☐ Fit dentures ☐ Support stockings

☐ Fit callipers / splint / aid ☐ Limb protectors ☒ Other assistance given: Socks and shoes

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Given Name	DOB	GENDER
RON	9/1/1954	M
Address		Post Code
5555 DONOVAN ST, AUGUSTA, WA		6290
	Telephone	
	08 9758 1227	

Skin Integrity: wound care, pressure injury prevention and management, pressure injury alert sticker
Complete Comprehensive Skin Assessment (MR 124B) & Braden Assessment (MR124) on admission and weekly

Additional charts in use: ☐ Wound Management Plan (MR122)

Anti-pressure interventions: ☒ Bed: Overlay Chair: Roho cushion

Seating Requirements: Firm upright chair

Positioning schedule:

Identified risk: ☐ Low ☒ Medium ☐ High

Safety requirements (include the provision of special bed rails / authorised restraints / safety strategies / alarms):

Alarm mat by side of bed

Toileting

☒ Independent ☐ Position assist ☐ Hygiene assist ☐ Clothing assist ☒ Toilet

☐ Commode ☐ Day ☐ Night ☐ Pan ☐ Urinal ☐ Other: Complete Specific Care Plan (RC6)

Bladder ☒ Complete 3 day Bladder Chart and Continence Assessment and Plan (RC 17)

Continent: ☒ Yes ☐ No Incontinent: ☐ Day ☐ Night Aids: ☐ Catheter ☐ Urodome

Pads worn: ☐ Day Pad Type / Change scheduled: _____

☐ Night Pad Type / Change scheduled: _____

Bowels Refer to Continence Advisor / Nurse ☐ Yes ☒ No Complete Continence Assessment / Plan (RC 18) ☒

Continent: ☒ Yes ☐ No Aperients used: ☐ Yes ☒ No ☐ Stoma Care ☐ Other:

Behaviour Management Complete Behaviour Assessment, Evaluation and Plan (RC 13) Date:

Behaviour Management / Emotional support / strategies:

N/A

☐ Seniors Mental Health Referral ☐ Geriatrician ☐ DBMAS Referral

☐ Restraint authorisation completed (RC 43) Bed rails not to be used except for support or to turn in bed.

Social and Human / Cultural Needs
Refer to Aboriginal Liaison Officer ☐ Chaplain ☐ Social Worker ☐

Religious Activities: ☐ Attends church services Usual Time / Place:

Special cultural / Lore / spiritual days / routines:

N/A

Family / friends / support systems:

☒ Family conference (RC 25) Month Due:

Discussed with Resident / Representative:		**Signature:** (Resident may initial)	
Ron Johnson		R Johnson	
Completed by (print name):	**Designation:**	**Signature:**	**Date:**
Jean Smith	RN	*J Smith*	02/09/YY

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UPDATED / REVIEWED				**UPDATED / REVIEWED**			
Date	**Initial**		**Related to which outcome?** e.g. pain, toileting etc.	**Date**	**Initial**		**Related to which outcome?** e.g. pain, toileting etc.
	Staff	**Resident**			**Staff**	**Resident**	

NB: Care Plan to be reviewed 3 monthly by RN / EN

WACHS VERSION EFFECTIVE: 14 MARCH 2017

Adapted from Acorn Care Plan (RC7 08/09) developed by Gevers Goddard Jones Pty Ltd and modified with permission for WACHS.