dacs
DEMENTIA & AGED CARE SERVICES

CHSP Client Care Plan

CLIENT DETAILS	
Full Name:	Preferred Name:
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other
Address:	
Phone Number:	Mobile Number:
Email:	
CLIENT REPRESENTATIVE DETAILS	
Full Name:	Relationship:
Address:	
Phone Number:	Mobile Number:
Email:	
CLIENT COORDINATOR DETAILS	
Coordinator Name:	Phone Number:
ACAT Assessment: ☐ Yes ☐ No	MAC Referral Number:
Date of Care Plan:	Review Date:
MEDICAL AND HEALTH NEEDS	
Doctor Name:	Practice Name:
Address:	
Phone Number:	Email:
Preferred Hospital:	
Chemist/Pharmacy:	
Phone Number:	
Medical Conditions/Diagnosis:	
Hospital Admissions in past 12 months? ☐ Yes ☐ No *If yes, provide details below*	
Falls in past 6 months? ☐ Yes ☐ No *If yes, provide details below*	

FRAT Assessment Completed? ☐ Yes ☐ No ☐ N/A		Date:
Completed by:		
Medications: ☐ Morning ☐ Noon ☐ Night		
Client Medication Assessment Completed: ☐ Yes ☐ No ☐ N/A		Date:
Completed by:		
Allergies		
Alerts		
Dignity of Risk		

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT 000 FOLLOWED BY MY CONTACTS OUTLINED BELOW

Contact One:	Contact Two:
Phone:	Phone:

PLAN FOR NON-RESPONSE TO A SCHEDULED VISIT

☐ Repeat Knocking	☐ Call Contacts Above	☐ Call Client
☐ Contact Police	☐ Contact Neighbour	☐ Access via Key Safe
☐ Other:		Key Safe Code:

EMOTIONAL AND PSYCHOSOCIAL CONCERNS *(select all that apply)*

☐ Anxiety	☐ Aggression	☐ Delusion
☐ Hoarding	☐ Sexually inappropriate behaviour	☐ Restlessness/Agitation
☐ Hallucinations	☐ Refusal of care	☐ Wandering
☐ Other, *please specify*		

Behaviour/Triggers:

Management Plan:

COMMUNICATION

Primary Language:		Other Language/s:
☐ Coherent/Clear	☐ Jumbled	☐ Reduced Content
☐ Word Finding Difficulty	☐ Converses with Others	☐ Able to Communicate Effectively
Able to communicate needs effectively? ☐ Yes ☐ No		

☐ Follows conversations	☐ Follows simple/short instructions	☐ Comprehends written instructions
Additional Comments:		

MOBILITY			
Mobility Assessment Completed? ☐ Yes ☐ No ☐ N/A			Date:
Completed by:			
☐ 4 Wheel Walker	☐ Walking Stick	☐ Wheelchair	
☐ Nil Walking Aids	☐ Independently Mobile	☐ Other	
If other, specify:			
Level of Assistance:			
Transfers:			
Stairs:			
Additional Comments:			

COMPLEX HEALTH CARE NEEDS *(select all that apply)*		
☐ Diabetes	☐ Pain	☐ Modified Diet
☐ Fragile Skin	☐ Respiratory Condition	☐ Heart Condition
☐ Other		
Management Plan:		

COGNITIVE STATUS			
PAS Assessment? ☐ Yes ☐ No ☐ N/A			Date:
Completed by:			
Confusion: ☐ Mild	☐ Moderate	☐ Severe	☐ Variable
Orientated: ☐ Person	☐ Place	☐ Date	☐ Time of Day
Memory Difficulties:	☐ Short Term	☐ Long Term	
Insight into Difficulties: ☐ Yes ☐ No			
Requires Additional Cognitive Assessment: ☐ Yes ☐ No			

Comments:						
SENSORY LOSS						
Vision:	☐ Normal	☐ Impaired		Glasses required:	☐ Yes	☐ No
Hearing:	☐ Normal	☐ Impaired		Hearing aids:	☐ Yes	☐ No
Comments:						
LIFESTYLE AND ACTIVITIES						
Lifestyle Assessment?	☐ Yes	☐ No	☐ N/A	Date:		
Completed by:						
Lifestyle Choices, Cultural and/or Religious Needs:						
Hobbies & Interests:						
Short Term Goals:						
Long Term Goals:						
PERSONAL CARE SUPPORT						
Hygiene Assessment?	☐ Yes	☐ No	☐ N/A	Date:		
Completed by:						
Skin Integrity Assessment?	☐ Yes	☐ No	☐ N/A	Date:		
Completed by:						
Showering – when showering I require someone to *(select which applies)*						
☐ Assist	☐ Supervise	☐ Set-up	☐ Independent			
Preferred Time:	☐ AM	☐ PM				
Equipment:						

Comments:

Dressing – when dressing I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
Please assist me to:	☐ Select/Change	☐ Put on/Take off	☐ Fasten (zips/clasps)

Comments:

Grooming – when attending to my personal grooming I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
Please assist me to:	☐ Shave	☐ Style my hair	☐ Apply make-up

Comments:

Oral Hygiene

Oral Hygiene Management Plan? ☐ Yes ☐ No ☐ N/A | Date:

Completed by:

When attending to my oral hygiene needs, I require someone to *(select which applies)*

☐ Assist ☐ Supervise ☐ Set-up ☐ Independent

Dentures: ☐ Yes ☐ No If yes, please specify below

☐ Full Denture ☐ Partial - Top ☐ Partial - Bottom

Comments:

Continence Support

When attending to my toileting needs, I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
☐ Urinary Incontinence	☐ Bowel incontinence	☐ Toileting Program	
☐ Continence Aids (Pads)	☐ Catheter		

Comments:

NUTRITIONAL SUPPORT				
Dietary Assessment?	☐ Yes	☐ No	☐ N/A	Date:
Completed by:				
When attending to my dietary needs, I require someone to *(select which applies)*				
☐ Assist	☐ Supervise	☐ Set-up	☐ Independent	
Likes:				
Dislikes:				

INSTRUMENTAL ACTIVITIES OF DAILY LIVING			
Cleaning:	☐ Dependent	☐ Assisted	☐ Independent
Cooking/Meal Preparation:	☐ Dependent	☐ Assisted	☐ Independent
Gardening:	☐ Dependent	☐ Assisted	☐ Independent
Laundry:	☐ Dependent	☐ Assisted	☐ Independent
Do you have a Taxi Subsidy Card?	☐ Yes	☐ No	☐ N/A
Do you have a Disability Parking Permit?	☐ Yes	☐ No	☐ N/A
Do you have a Companion Card?	☐ Yes	☐ No	☐ N/A
If no, would you like assistance to apply?	☐ Yes	☐ No	☐ N/A
Comments:			

DAILY ROUTINE
Usual morning routine *(wake up time, exercise etc.):*
Usual afternoon routine:
Usual evening routine *(time for bed, activities etc.):*
Sleeping Pattern *(strategies used when unable to sleep etc.):*

Meal	**Time** *(usual/preferred time)*	**Comments** *(inc. preferred meal)*
Breakfast:		
Morning Tea:		
Lunch:		
Afternoon Tea:		
Dinner:		
Snacks:		

DOMESTIC ASSISTANCE

Domestic Assistance funder under commonwealth Home Support Programme (CHSP).

Domestic Assistance will be provided in the home and refers to:

- General house cleaning
- Linen services
- Unaccompanied shopping (deliver to the home)

Domestic Assistance can include:

- Dishwashing
- House cleaning (can include vacuuming, mopping, cleaning bathrooms and kitchens)
- Clothes washing and ironing (can include changing sheets and making beds)
- Shopping (unaccompanied)
- Bill paying (unaccompanied)

Please **discuss additional domestic** needs with our friendly staff who will endeavour to complete tasks to your satisfaction within Workplace Health and Safety Regulations. Services will be completed during allocated times.
Staff will use a Residual Current Device (RCD), this will be plugged into your electrical socket during your service to protect your workers from electrical shock. This does not affect your system, nor does it cost you any additional money on your electrical bill.
Clients are asked to please:

- Ensure equipment is kept in a safe, unfaulty condition
- Provide a squeeze mop and plastic bucket
- Provide non-corrosive cleaning products in their original labelled containers

ROUTINE TASKS FOR COMPLETION

Vacuum/ Sweep:	☐ Lounge	☐ Dining	☐ Kitchen	☐ Hall
	☐ Veranda	☐ Bedrooms	☐ Study	☐ Toilet
	☐ Bathroom	☐ Other:		
Mop:	☐ Lounge	☐ Dining	☐ Kitchen	☐ Hall
	☐ Veranda	☐ Bedrooms	☐ Study	☐ Toilet
	☐ Bathroom	☐ Other:		
Bathroom:	☐ Basin	☐ Bath	☐ Shower	☐ Wall Tiles
	☐ Other:			
Toilet:	☐ Bowl	☐ Pedestal	☐ Other:	

Additional Regular Tasks:

REQUESTED SERVICES				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				

CARER PROFILE				
Name:		Relationship:		
Carer Overview *(History, Roles, Social Activities, Interests, Social Support etc.)*				
Availability of informal support to support carer:	☐ Yes	☐ No		
Are other services used to support carer/client?	☐ Yes	☐ No		
Is the care recipient's health deteriorating?	☐ Yes	☐ No		
Is the caring role sustainable?	☐ Yes	☐ No		
Are there other demands on the carer?	☐ Yes	☐ No		
Provide Details:				

ASSESSMENT COMPLETION	
Coordinator Name:	Date:
Coordinator Signature:	
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	

Review One	
Review Completed By:	Date:
Staff Signature:	Role:
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	

Comments:

Review Two	
Review Completed By:	Date:
Staff Signature:	Role:
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	
Comments:	

Review Three	
Review Completed By:	Date:
Staff Signature:	Role:
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	
Comments:	