Bell Care Services – Protocol – ADL Care Plan

Why do we need a Care Plan?

Care plans should be implemented for all care going into a client's home to ensure that:

- The appropriate care/service is being provided
- Care/services provided are structured & encompass areas that may affect service delivery such as OH&S issues
- That the client is able to participate & consent to the care/services
- Staff unfamiliar to the client are able, by reading the plan, to provide the care required

Advantages

- All care providers can see, at a glance, what services are being provided without asking the client. (*This includes the clients relatives, GP and all allied health professionals*)
- Because the client has participated and consented to the care plan, they are aware exactly what services are going to be provided
- Equipment required to provide the service can be organised
- OH&S policies can be reinforced & hazards reduced
- Reduces the amount of writing on the intervention sheet

Disadvantages

- Extra time required initially to complete the care plan
- Extra time to review the care plan every 12 weeks

Completing the Care Plan

Clients Name: Insert the clients full name here.

D.O.B: Insert the clients date of birth here.

Frequency: Circle the days clients will be receiving visits. If you do not know ring the office and we will be able to tell you.

Infection Control: This section indicates to all staff that they must follow Bell Care Services Infection Control Policy.

Workplace Health & Safety: This section indicates to all staff that they must use all safety equipment that has been supplied to clients. This equipment has been supplied to make the service safe for the client and the support worker and **MUST** be used.

Preparation: Circle yes or no to indicate whether the client requires assistance to select appropriate clothing or to organise towels etc for shower.

Transferring/Mobility/Toileting: Tick the appropriate box indicating the level of assistance required by the client for mobility, toileting, transferring and dressing/undressing.

You need to document the safety equipment the client uses for these tasks.

Method: This section tells you how the personal care is provided. You need to circle the appropriate response to each question.

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You need to list all safety equipment that is to be used by staff and the clients during the service.

Comment: Is where you write any information relevant to this client.

Date & Completed: Insert the date the ADL Care Plan is completed here.

Name & Designation of Staff Member: Write your name and designation here (e.g. RN, EN, AIN) and sign here.

3 Monthly Review Date: Write the date the care plan is to be reviewed here. The review date should be 3 months from the date completed.

Client Consent: complete the care plan with the client's participation. Make sure the client signs the care plan. If you are the first person into the client, do not forget that you need to make sure they also sign a consent form.

Please Note:

A new ADL Care Plan must be completed every 3 months to make sure that the information is current. Our client's conditions can deteriorate or improve over 12 weeks and the ADL Care Plan should reflect these changes.

When you are at the client's homes providing personal care services, check the care plan to see if it has reached it's review date. If it has, complete a new care plan, put it in the file and bring the old one back to the office.

If the service takes longer because you have to redo the care plan, just make a note. E.g. extra time needed to complete ADL Care Plan.