Health
Western NSW
Local Health District

Facility:

Residential Aged Care Interim/Admission Care Plan

GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Insert/Attach Named & Dated Photo of Resident Here

Resident Name: _____

D.O.B.: _____ **D.O.A.:** _____

Unit: _____ **Rm. No.:** _____

Attach Bradma/Resident Label Here

Diagnosis on Admission:

Religion:

Please Note: This is an Interim Care Plan ONLY. It must be completed within 24 hours of admission and is valid only until the Long Term Care Plan is completed within 21 days of admission. All relevant assessments are to be commenced within the first 24 hours of admission.

Communication/Comprehension: **Language/s Spoken:**

Aids: Hearing Aids ☐ Left ☐ Right ☐ Glasses: ☐ Reading Only ☐ Wears at all times ☐

Other Aids Required:

Speech: Normal ☐ Impaired ☐ Comment:

Sight: Normal ☐ Impaired ☐ Comment:

Hearing: Normal ☐ Impaired ☐ Comment:

Comprehension: Normal ☐ Impaired ☐ Comment:

Assistance Required:

Nutrition & Hydration:

Diet: Normal ☐ Cut Up ☐ Soft/Minced ☐ Vitamised ☐

Fluids: Normal ☐ Thickened ☐ Consistency:

Aids: Normal ☐ Other:

Likes:

Dislikes:

Swallowing: Normal ☐ Identified Risk:

Food Allergies:

Reaction:

Cultural Considerations:

Assistance Required:

Mobility/Transfers: Independent ☐ Requires Assistance ☐

Weight Bearing ☐ Non-Weight Bearing ☐ Transfers: 1 to assist ☐ 2 to assist ☐ Standing Machine ☐ Lifting Machine ☐

Ambulates: Independently ☐ Intermittent Supervision ☐ Supervision at all times ☐ Assist x 1 ☐ Assist x 2 ☐ Wheelchair only ☐

Aid Used: Walking Stick ☐ 4 Prong Stick ☐ 2/4 Wheel Frame ☐ Other:

Mobility in Bed: Independent ☐ Prompt ☐ Slide Sheet Required ☐

Falls Risk: Yes ☐ No ☐ Unknown ☐

FORM TITLE

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Personal Hygiene:

Assistance: Independent ☐ Prompt/Remind ☐ Supervise & Prompt ☐ Partial Assist & Prompt ☐ Full Assist ☐ x1 ☐ x2 ☐

Bath ☐ Shower ☐ Daily - A.M./P.M. ☐ 2nd Daily - A.M./P.M. ☐ Other:

Face/Hands/Back/Groins Wash: A.M. ☐ P.M. ☐ Other:

Uses: Soap ☐ Bath Oil ☐ Type: Shave: Daily ☐ 2nd Daily ☐ Razor: Electric ☐ Safety ☐

Hair: Wash – Daily ☐ 2nd Daily ☐ Other: Uses: Shampoo ☐ Conditioner ☐

Oral Care:

Own Teeth ☐ Upper ☐ Lower ☐ | Dentures ☐ Partial ☐ Upper ☐ Lower ☐ Both ☐

Uses: | Clean: A.M. ☐ P.M. ☐ Other:

Continence:

Urine: Continent ☐ Incontinent ☐ Wears:

Faeces: Continent ☐ Incontinent ☐ Prone to Constipation ☐ Wears:

Toileting: Independent ☐ Remind/Prompt ☐ Assist with some Aspects ☐ Full Assistance ☐ x 1 ☐ x 2 ☐

Toileting Times A.M.												Toileting Times P.M.											
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

Skin Integrity:

Intact ☐ Impaired ☐ Dry/Flaky Skin ☐ Prone to Excoriation ☐ Wound/Break Present – See Wound Chart ☐

Positional Changes - A.M.												Positional Changes - P.M.											
1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12

Other Care:

Technical Nursing: Peg Tube ☐ IDC/SPC ☐ Colostomy ☐ O2 Therapy ☐ Nebulizer ☐

Pain Management: History of Chronic Pain ☐ History of Acute Pain ☐ History of Both ☐

Site/s & current management:

Sleep: Sleeps Well ☐ Disturbed Sleep Pattern ☐ Retires at: Gets Up at:

Comment:

What Works:

Known/Potential Behaviours:

Wandering ☐	Intrusiveness ☐	Verbal Disruption ☐	Aggression ☐	Withdrawal ☐
Dis-inhibition ☐	Swearing/Abusive ☐	Depression ☐	Risk Taking ☐	Danger to Others ☐
Confusion ☐	Anxiety ☐	Sexual Dis-inhibition ☐	Absconding ☐	☐

Other:

Medications: Self Administers ☐ Requires Assistance ☐ Compliant ☐ Non-Compliant ☐

Requires: Eye Drops/Ung ☐ Patches ☐ Injections ☐ Insulin ☐ Warfarin ☐ Regular/PRN S8 ☐

Social Considerations:

Date: _____ Completed By: _____ Designation: _____ Signature _____