Saint John of God Kerry Services
Person Centred Plan Assessment

Section 1 General Information

Surname: _____
Forename: _____
Name which person prefers: _____
Gender: Male _____ Female _____
Date of Birth: _____
Religion: _____
Next of Kin: _____
Address: _____
Relationship: _____
Tel No: Home _____ Mobile: _____
Other Contact
Name: _____
Address: _____
_____
Relationship: _____
Tel No: Home _____ Mobile: _____

Medical Emergency Information _____
_____
_____
_____
_____
DNR Status: _____
Diagnosis: _____
_____
_____
Do You Have Known Allergies? Yes / No
If Yes List Cause and Reaction
_____
_____
_____
Date Of Admission: _____
Medical Card No: _____
Hospital No: _____
PPS No: _____

Baseline Observations

Weight: 	Temperature; Pulse;	Smoker:  Yes/No	Drink Alcohol:  Yes/No
Height:  Build	BP: Respirations:	Number of cigs per day?	Units per week?
Body mass index (Appendix 1)	**Eye Colour**	**Skin Type**	**Hair**

Do You Have any of the following Conditions

Diabetes	**Epilepsy**	**Respiratory Conditions**	**Cardiac**	**Coeliac**
Management Plan Yes No	**Management Plan Yes No**	**Details**	**Details**	**Details**

Assessment Date & Signature _____Year 1 Review Date & Signature _____Year 2 Review Date & Signature_____

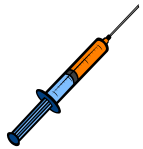
Section 2: Historical Profile **Past Medical History**

Date	Details

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 2: Historical Profile

Past Medical History



Vaccinations

Vaccinations *(please circle and enter dates as appropriate)*		Date	Date	Date
Polio:	Yes / No			
MMR:	Yes / No			
Influenza:	Yes / No			
Hepatitis Vaccination Program:	Yes / No			
Seasonal Flu:	Yes / No			
H1N1 Swine Flu:	Yes / No			
BCG:	Yes / No			
Diphtheria:	Yes / No			
Other				
Tetanus		Date First	Date Booster	Date Booster

My family Medical history (e.g.) Diabetes, Heart Disease, Breast Cancer Osteoporosis, epilepsy

Any Problems/special requirements in relation to medication? Yes ☐ No If Yes, please specify:

☐My Last Medication Review was on _____

Doctor Who Conducted Review: _____

My Last Psychiatric Medication Review _____

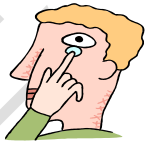
Doctor Who Conducted Review: _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 3 Synopsis of Physical Profile

Vision

Left Eye: Good ☐ Fair ☐
Right Eye: Good ☐ Fair ☐
Wear Glasses: Yes ☐ No ☐
Date of Eye Test: _____
Comment: _____



Are You Registered Blind Yes ☐ No ☐
Do You Have Cataracts Yes ☐ No ☐
Do You Have Glaucoma Yes ☐ No ☐
Do You Have Detached Retina Yes ☐ No ☐
Do you have any other eye condition _____

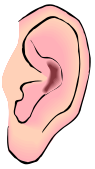
Haemoglobin:

Date& Result	Date & Result	Date & Result
_____	_____	_____
_____	_____	_____
_____	_____	_____

Associated Conditions

Epilepsy	Yes ☐	No ☐
Respiratory	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
Diabetic	Yes ☐	No ☐
Cardiac	Yes ☐	No ☐
Allergies	Yes ☐	No ☐
Skin Condition	Yes ☐	No ☐
Renal Conditions	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐

Comments _____
_____
_____



Hearing

Left Ear: Good ☐ Poor ☐
Right Ear: Good ☐ Poor ☐
Hearing Aid Yes ☐ No ☐
Prone to infection Yes ☐ No ☐
Wax Build Up Yes ☐ No ☐
Comments _____
Date Of Hearing test: _____

Breast Examination/ Prostate Examination

Date & Result	Date & Result	Date & Result
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Menstruation

Give Details: _____
How are PMS symptoms displayed: _____
_____
How are your symptoms managed: _____
_____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 3 Synopsis of Physical Profile

WOMEN'S HEALTH	**Details**
Date of last examination: Details	
Cervical Smear:	
Are you registered for cervical smear screening programme	
Breast Examination:	
Mammogram:	
Blood Test for Menopause:	
If over 50 Are you registered with National Breast screening programme	
Comment	
MEN'S HEALTH	**Details**
Date of last examination:	
Prostate:	
Testicular:	
Comments	

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4: Activities of daily living

Maintaining a safe environment

Awareness of dangers in home environment Yes ☐ No ☐
Awareness of dangers in outside environment Yes ☐ No ☐
Can safeguard Privacy/dignity Yes ☐ No ☐
Can safeguard personal belongings Yes ☐ No ☐
Has the ability to undertake/ practice the following measures independently:
Fire Safety Yes ☐ No ☐
Hazard Identification Yes ☐ No ☐
Road Safety Yes ☐ No ☐
Accident Prevention Yes ☐ No ☐
Infection Control Yes ☐ No ☐
Seeks direction Yes ☐ No ☐
Use public transport Yes ☐ No ☐
Requires any special precautions/ support in any situation/ circumstances Yes ☐ No ☐
If yes, Please specify:

Has Your individual Safety Assessment Been Completed Yes/ No
If Yes Date Complete Last Review Date Next Review Date

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS

Breathing

Problems with breathing	Yes ☐	No ☐
If Yes, Please specify:		
Prone to coughs	Yes	No ☐
Prone to chest infections	Yes	No ☐
Prone to pneumonia	Yes	No ☐
Use of nebulisers / inhalers	Yes	No ☐
Requires Postural drainage	Yes	.No ☐
Requires physio i.e. chest physio	Yes	No ☐
Respiratory Condition	Yes	No ☐
Prone to aspirating	Yes	No ☐
Specific position for comfort	Yes	No ☐
Aids required	Yes	No ☐
Oxygen Therapy	Yes	No ☐
Asthmatic	Yes	No

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 – ADLS, *Contd.*

Communication

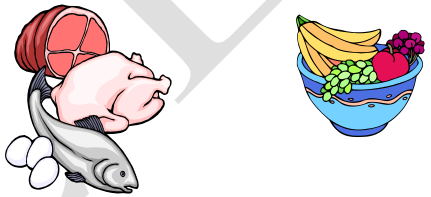
Have You Completed Speech and Language Assessment Yes No Date
Recommendations:

Do you Speak verbally Yes ☐ No ☐
Do you Use some words Yes ☐ No ☐
Has a communication system Yes ☐ No
Details e.g. Picture Exchange, Objects of Reference, Communication Passport, Individual profile, complete Communication board, Other

Communicates using words gestures body language
☐
Indicates pleasure/ displeasure by vocalisation Yes ☐ No ☐
Is speech clear ☐ unclear ☐ No speech ☐
Impairment which hinder speech/ communication Yes ☐ No ☐
Can be understood by family, staff, peers but difficult for strangers Yes ☐ No ☐
Gestures/ which person may convey their needs ☐ Yes ☐ No ☐
Understands a large range of commands / words ☐ Yes ☐ No ☐
Understands a range of commands/ words ☐ ☐ Limited range Large Range ☐
Understands a range of non verbal prompts ☐ Limited range Large Range

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

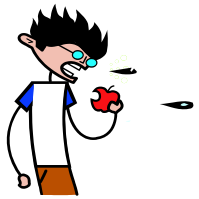
Section 4 - ADLS, *Contd.*



Nutrition

Appetite:	Good ☐	Poor ☐	
Special Diet required:	Yes ☐	No ☐	specify _____
Swallowing difficulty:	Yes ☐	No ☐	specify _____
Prone to aspirating:	Yes ☐	No ☐	
Supplementation required	Yes ☐	No ☐	Type _____
Peg/NG tube required:	Yes ☐	No ☐	Specify regime _____
Appropriate weight for height:	Yes ☐	No ☐	
Assessed By Dietician	Yes ☐	No ☐	

Recommendations:



Assessed by speech therapist: Yes ☐ No ☐
Recommendations:

Preferences:

Food
Likes
Dislikes

Beverages
Likes
Dislikes

Food Allergies: _____

Assistance required with feeding Yes ☐ No ☐ Feeding cup ☐ Glass ☐ Beaker ☐
Assistance required with drinking Yes ☐ No☐ Feeding aids: Specify: _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Oral Hygiene

Dental Caries Yes ☐ No ☐ Comment: _____
Dentures Yes ☐ No ☐ Comment: _____
Braces Yes No ☐ Comment: _____
Healthy gums Yes ☐ No ☐ Comment: _____
Ability to brush teeth Yes ☐ No ☐ Comment: _____

Requires use of oral hygiene products e.g. mouth care packs, mouthwash _____
_____

Do You Experience dental Pain/Discomfort or Sensitivity Yes ☐ No ☐
Comment: _____

Last Dental Appointment

_____
_____
Outcome _____
_____
_____

Specific Requirements/ supports for Dental visits

_____
_____
_____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Clothing / controlling body temperature

Select clothing appropriately:

Warm weather clothing	Yes	☐	No	☐
Cold weather clothing	Yes	☐	No	
Wet weather clothing	Yes	☐	No	☐
Day/ Night clothing	Yes	☐	No	
Indoor clothing	Yes	☐	No	☐
Appropriate footwear	Yes	☐	No	

Shoe Size _____
Bra Size _____
Clothes Size _____
_____
Special Considerations _____
_____

Independent maintenance of body temperature/ Prevention of hypothermia **Yes** ☐ **No** ☐
If No Please Specify? Detail Management Plan If Required

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Skin Condition

Presence of ulcers, lacerations, bruising, oedema, rashes, Moles, Eczema, Psoriasis, Dermatitis Yes ☐ No ☐
(Please indicate on Body Map)
Comment:

Are you at risk from developing pressure sores has an action plan been developed with you? E.g. mattress seating
Has a Norton Scale Been Completed (Appendix) Yes No

Pressure areas intact Yes ☐ No ☐
Presence of risk factors predisposing to tissue breakdown e.g. reduced mobility ☐
Obesity, below average weight ☐ Incontinence ☐ other ☐

If other, specify: _____

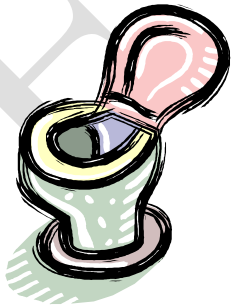
Do you have Swelling of feet or Hands Yes No
Do You Have Varicose Veins Yes No
Do you have cold extremities Yes No
Comment:

Foot Care

Do you attend Chiropodist Yes ☐ No ☐ If Yes, Name _____
Do you attend podiatrist Yes ☐ No ☐ If Yes, please specify _____ Name: _____
Comment

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*



Elimination

Any relevant digestive medical condition, urinary system

Frequency Yes ☐ No ☐
Incontinence Yes ☐ No ☐
Enuresis Yes ☐ No ☐
Retention Yes ☐ No ☐
Uses continence wear Yes ☐ No ☐ if yes, size _____ Type _____
Are you prone to urinary tract infections (U.T.I) Yes ☐No ☐
If Yes, please Specify: _____

Urinary Catheter in situ Yes ☐ No ☐
Any relevant medical condition _____

Bowel Pattern

Regular Yes ☐ No ☐
Diarrhoea Yes ☐ No ☐
Encropresis Yes ☐ No ☐
Constipation Yes ☐ No ☐
Any relevant medical condition _____

Toilet hygiene

Self caring	Yes ☐	No ☐
Needs assistance	Yes ☐	No ☐
Needs all care	Yes ☐	No ☐
Flushes toilet independently	Yes ☐	No ☐
Flushes when prompted	Yes ☐	No ☐
Never flushes toilet	Yes ☐	No ☐
Washes hands independently	Yes ☐	No ☐
Washes hands when prompted	Yes ☐	No ☐
Never washes hands	Yes ☐	No ☐

Comment _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

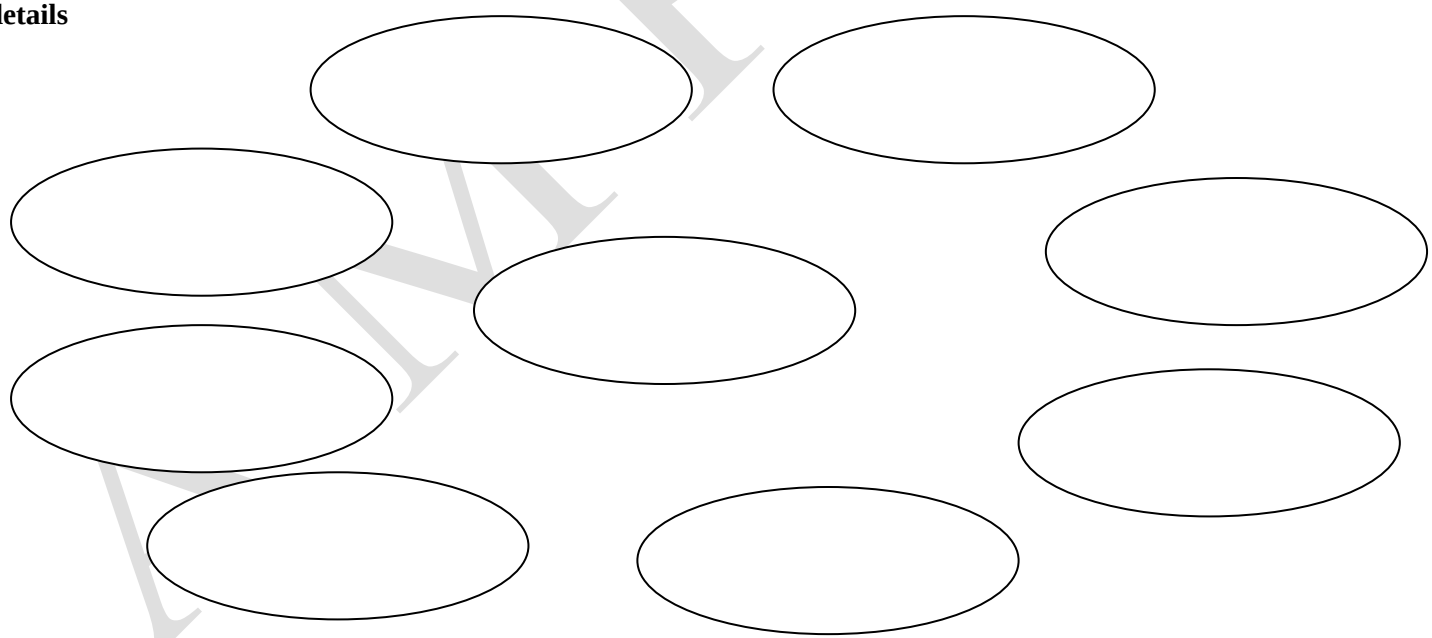
Expressing Sexuality

Do you express affection appropriately	Yes ☐	No ☐
Do you expresses sexuality appropriately	Yes ☐	No ☐
Do you have friends	Yes ☐	No ☐
Do you have an intimate partner	Yes ☐	No ☐
Are you sexually active	Yes ☐	No ☐
Do you use contraceptives	Yes ☐	No ☐

If yes, please give reason: _____

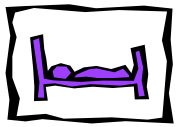
Have you received Education re: sexual Health Yes ☐ No☐

Who are the people in your Circle of Support?
Include family members, volunteers, and friends as well as paid staff members.
Name, Support role and contact details



Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*



Sleeping

Do you have or experience the following?

Regular sleep pattern	☐	Yes	☐	No	☐	Hours of sleep: _____
Disturbed sleep pattern	☐	Yes	☐	No	☐	
Insomnia	☐	Yes	☐	No	☐	
Difficulty in going to sleep	☐	Yes	☐	No	☐	
Early morning waking	☐	Yes	☐	No	☐	
Use of Medication	☐	Yes	☐	No	☐	
Sleepwalks	☐	Yes	☐	No	☐	
Nightmare	☐	Yes	☐	No	☐	
Nocturnal Apnoea	☐	Yes	☐	No	☐	
Use aids for sleep	☐	Yes	☐	No	☐	
Bedtime routine	☐	Yes	☐	No	☐	

Details of Routine:

Do you have a Physiotherapy Assessment Completed? Yes ☐ No ☐

If Yes, Date Completed: _____ Last review date: _____

Recommendations e.g. Positioning / Sleep System

Details:

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Mobility

Sit Independently	Yes ☐	No ☐	Spinal Deformities	Yes ☐	No ☐
Stands Independently	Yes ☐	No ☐	Contractures	Yes ☐	No ☐
Walks Independently	Yes ☐	No ☐	Problems with balance	Yes ☐	No ☐
Need aid to walk	Yes ☐	No ☐	Problems with hand eye co-ordination	Yes ☐	No ☐
Manual handling needs	Yes ☐	No ☐			
Uses wheel chair	Yes ☐	No ☐			
Do you wear special footwear	Yes ☐	No ☐			
Assessed by physiotherapist	Yes ☐	No ☐	Date: Date	Date	
Recommendations					
Assessed by occupational therapist	Yes ☐	No ☐	Date: Date	Date	
Recommendations					

Special needs handling: _____
No of handlers: _____
Equipment(s) required: _____
Size/type of sling: _____
Special needs (joints/wounds): _____
Recommended Position changes

Stairs

Climb stairs independently	Yes ☐	No ☐
Descends stairs independently	Yes ☐	No ☐
Climbs stairs with help	Yes ☐	No ☐
Descends stairs with help	Yes ☐	No ☐
Cannot climb stairs	Yes ☐	No ☐
Can use escalator	Yes ☐	No ☐

Additional Comments:

Arm Movement

Uses both independently	Yes☐	No
Only partial controlled use	Yes☐	No
Dominant arm	left	right

Hand grasps

	Left		Right	
Full use of grasp	Yes ☐	No☐	Yes☐	No ☐
Partial grasp	Yes ☐	No ☐	Yes☐	No ☐
cannot grasp	Yes ☐	No ☐	Yes☐	No ☐

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Dressing:

Dressing:

Can dress self independently	Yes ☐	No ☐
Can partially dress with assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No ☐
Can choose clothing	Yes ☐	No ☐

Undressing:

Can undress self independently	Yes ☐	No ☐
Can partially undress self	Yes ☐	No ☐
Needs full assistance	Yes ☐	No

Fastens:

Buttons	Yes ☐	No ☐
Buckles	Yes ☐	No ☐
Clips	Yes ☐	No ☐
Zips	Yes ☐	No ☐
Laces	Yes ☐	No ☐

Personal Hygiene:

Bathing/Showering:

Prefers bath or shower _____

Can wash/bathe independently	Yes ☐	No ☐
Can wash/bathe with assistance	Yes ☐	No
Needs full assistance	Yes ☐	No ☐

Any special requirements i.e. soap, creams:

Comment: _____

Dries self independently	Yes ☐	No ☐
Dries self with assistance	Yes ☐	No ☐

☐
☐

Washing hair

Can wash hair independently	Yes ☐	No ☐
Can wash hair with assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No

Any special requirements i.e. shampoo:

Comment _____

Can use hairdryer	Yes ☐	No ☐
Can comb/brush hair independently	Yes ☐	No
Needs full assistance	Yes ☐	No ☐

Comment _____

Attends hairdresser	Yes ☐	No

Comment _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Personal Hygiene:

Can wash face/hands independently	Yes ☐	No ☐
Can wash face/hands with assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No ☐
Any special requirements i.e. soap/cream	Yes ☐	No ☐

If yes please specify: _____

Oral hygiene:

Can wash teeth/dentures independently	Yes ☐	No ☐
Can clean teeth/dentures with assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No ☐
Any special requirements i.e. Corsodyl, gel, Oraldene	Yes ☐	No ☐

If yes please specify: _____

Shaving:

Can shave independently	Yes ☐	No ☐
Needs assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No ☐

Comment: _____

Menstruation:

Can independently take care of menstruation	Yes ☐	No ☐
Needs assistance	Yes ☐	No ☐
Needs full assistance	Yes ☐	No ☐

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Working / Playing/Activities

What work/activities do you attend?	**Personal Outcome Goals Year 1** 1. 2. 3. 4.
What work/activities do you attend? List Days/Times	
What interest/ hobbies do you enjoy? Yes ☐ No ☐ List	**Personal Outcome Goals Year 2** 1. 2. 3. 4.
What clubs/ groups do you attend? Yes ☐ No ☐ List	
What activities do you most enjoy? Yes ☐ No ☐ List	
What activities do you least enjoy? Yes ☐ No ☐ List	**Personal Outcome Goals Year 3** 1. 2. 3. 4.
Will initiate own activities Yes ☐ No ☐ List	
Will participate in activities id prompted? Yes ☐ No ☐ List	
Unable to initiate activities? Yes ☐ No ☐	Full Personal Outcomes Details in Outcomes Section of Person Centred Plan

Exercise how often? Never ☐ Seldom ☐ Sometimes ☐ frequent ☐
Types of exercise:
Gymnasium Yes ☐ No ☐
Treadmill Yes ☐ No ☐
Indoor games Yes ☐ No ☐
Swimming Yes ☐ No ☐
Horse riding Yes ☐ No ☐
Bowling Yes ☐ No ☐Other please specify : _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Behaviour

Do You Have Behaviour Support Needs Yes □ No

Brief description of behaviours requiring support

□

Have you had Multi Element behaviour Support Plan Developed Yes No

If yes, is your Plan _____Active _____Inactive

Is your plan scored i.e. is the periodic service review completed Yes No

If Yes What is The current % Scored _____%

Is Behaviour data recorded minimum monthly Yes No

What was the Communication Function of Your Behaviour Assessed As?

Has a risk assessment being completed to support you and others? Yes □ No

If yes what are the recommendations from risk Assessment

List possible causes/triggers that contribute to your Behaviour

_____

_____

_____

List known warning signs: _____

_____

_____

What approach do staff use to support your behaviour

_____

_____

List interventions staff should take in a crisis to manage your behaviour as outlined in MEBS

_____

_____

If No MEBs Plan in place has a referral been made _____ By Whom _____ Date _____

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

Section 4 - ADLS, *Contd.*

Dying

Is person receiving palliative care	Yes	No
Understanding of own mortality	Yes	No
Understanding of other people mortality i.e family, fellow peers	Yes	No
Realisation of own impending death	Yes	No
Wishes to see religious minister	Yes	No

Deceased family members:

Name	Relationship

Comments

Assessment Date & Signature _____ Year 1 Review Date & Signature _____ Year 2 Review Date & Signature _____

HEALTH CHECK SCREENING
ST JOHN OF GOD KERRY SERVICES

Name:_____ **DOB:**___/____/____ _____
Medical Card Number

Address:_____

Current Medication:_____**Allergies:**_____
_____ _____

Past Medical History:_____
_____
_____

Assessment:

BP:_____**Pulse:**_____**Resp:**_____**Temp:**_____**Weight:**_____

E.N.T.:_____

Chest/Lungs:_____

Cardiovascular:_____

Abdomen: _____

Musculoskeletal:_____

Nervous System:_____

Endocrinology:_____

Cervical Smear: □
Breast Check: □
Other:_____
Testicular Examination □
Prostate Examination □

Laboratory Investigations:

Haematology:	**Results:**	**Microbiology**	**Results**
FBC (Diff) □			
Biochemistry:		**Urinalysis** □	
U&E □			
Cholesterol □			
Liver Profile □			
Kidney Profile □		**MSU** □	
Glucose □			
TFT		**Stool** □	
Menopause Profile □			
PSA □			
Other_____			

Clinical Investigations/Referrals:

X Ray:_____	**Results:**
ECG: _____	
Other: _____	
Referrals:	

General Practitioner: _____ Signature: _____ Date: _____