CARE PLAN NORTHSIDE

File No.

To guide Community Team Carers, Structured Respite Providers & Kid's Club Support Workers in the cares your child requires.

Child's Name _____ D.O.B. _____

Home Address _____

_____ Postcode _____

Mother/Guardian _____

Address (If Different) _____

_____ Postcode _____

Phone Home _____ Work _____

Mobile _____

Father/Guardian _____

Address (If Different) _____

_____ Postcode _____

Phone Home _____ Work _____

Mobile _____

Siblings Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Contact Person in Case of Emergency:

Name _____ Phone No. _____

Relationship: _____ Mobile No. _____

Medicare No. _____

Healthcare Card No. _____

Family Doctor _____ Phone No. _____

Clinic Address _____

Hospital Usually Attended _____

Height _____ Weight _____

Allergies (drug, food) _____

Reaction

_____

_____

Xavier Medication Chart in Use **Yes** ☐ **No** ☐

Do Medications need to be given by the support worker? **Yes** ☐ **No** ☐

AS YOUR CHILD'S CARES CHANGE, IT IS THE PARENT/S OR GUARDIANS RESPONSIBILITY TO PROVIDE REGULAR UPDATES TO THE CARE PROVIDER.

Date: _____ Signature: _____

Updated: _____ Signature: _____

Updated: _____ Signature: _____

IF YOUR CHILD BECOMES UNWELL, WE WILL:-

1. PHONE FAMILY; – if unavailable
2. CONTACT R.N ON CALL;
3. PHONE EMERGENCY CONTACTS LISTED ON CARE PLAN;
4. IF DEEMED NECESSARY, SEEK MEDICAL ADVICE.

IN AN EMERGENCY SITUATION, WE WILL:-

1. RING 000 FOR AN AMBULANCE – your child will be transported to the NEAREST hospital;
2. CONTACT FAMILY OR EMERGENCY CONTACTS;
3. CONTACT R.N. ON CALL & COORDINATOR.

In most circumstances, a Xavier staff member will accompany a child to the hospital.

This Care Plan has been read by the relevant Support Worker & The Daily Plan has been completed in conjunction with the Parent / Carer	Date:	_____	Signature:	_____
	Date:	_____	Signature:	_____
	Date:	_____	Signature:	_____
	Date:	_____	Signature:	_____

File No. :_____ Child's Name: _____ D.O.B. _____

1. HEALTH INFORMATION:

General Health (pressure areas, tone, reflux, osteoporosis, hips, respiratory, ear aches, vomiting etc)

NATURE OF DISABILITY

What is the nature of your child's disability/disabilities? (including medical diagnosis where possible).

2. EPILEPSY:

Does your child have Epilepsy? (seizures or fits) Yes ☐ No ☐ N/A ☐

Description of seizures

Frequency

Warning signs

Triggers

Does your child require emergency seizure medication? Yes ☐ No ☐

If yes an additional authority from your medical practitioner is required.

Name of medication

EPILEPSY EMERGENCY PROCEDURE:

Emergency Procedure to follow when your child has a seizure

Step 1

Step 2

Step 3

Step 4

Do you wish to be contacted if your child has a seizure while in the care of Xavier Staff? Yes ☐ No ☐

3. OXYGEN & SUCTIONING:

Does your child have oxygen at home? Yes ☐ No ☐

If yes, how often _____

What is the rate? _____

How is it delivered (prongs/mask etc) _____

Does your child require suctioning? Yes ☐ No ☐

If yes please provide details _____

_____

If your child has a tracheostomy please refer to special insert

4. COMMUNICATION:

What is your child's method of communication? (i.e. speech, non verbal, makaton, etc)

_____

_____

Does your child have any special words or gestures for:

Yes	_____	No	_____
Food	_____	Bed	_____
Discomfort	_____	Toilet	_____
Drink	_____	Other	_____
Other	_____	Other	_____

Does your child have any hearing loss?	Yes ☐	No ☐	_____
Does your child have grommets?	Yes ☐	No ☐	_____
Does your child wear hearing aids?	Yes ☐	No ☐	_____
Does your child have any visual impairment?	Yes ☐	No ☐	_____
Does your child wear glasses?	Yes ☐	No ☐	_____

If yes, please provide the necessary details to ensure your child's needs are met.

_____

_____

_____

5. MOBILITY:

How does your child mobilise:

Manual wheelchair	☐	**Electric Wheelchair**	☐
Pram/pusher	☐	**Weight bear/assistance**	☐
Walker	☐	**walk**	☐
Crawl	☐	**rolls/shuffle on the floor**	☐

Please provide details _____

_____

_____

_____

6. HOISTING/LIFITNG:

How does your child mobilise:

Hoist	☐	**One person lift**	☐
Two person lift	☐	**Child self mobilise**	☐

Positioning _____

_____

_____

_____

Positions to avoid _____

_____

_____

_____

Positions to encourage _____

_____

_____

7. TRANSPORTATION:

Does your child transport well? Yes ☐ No ☐

Please provide details

How is your child transported?

Car:

Rear facing car seat (↑8kg) ☐
Forward facing car seat (8-26kg) ☐
Booster car seat (18-26kg) ☐
H Harness with Booster (18-26kg) ☐
H Harness only ☐
Other such as Trek Support ☐

Van: Wheelchair only ☐

In accordance with Australian Standards, Xavier staff are INSTRUCTED to transport children in vans with their head rest ON , tray Off and the wheelchair as upright as possible. Their chest harness or strap and pelvic strap must also be secured.

If you require any variation to the above, please speak to your Keyworker or Xavier Therapist and request an assessment. The assessment results will be added to this Care Plan below where required.

Assessment Required? Yes ☐ No ☐

Assessment Outcome

8. SAFETY & BEHAVIOUR:

Are there any particular behaviours that Carers should be aware of? Yes ☐ No ☐

How would you like us to respond to these behaviours?

Are there any particular fears, which we should know about?

9. SCHOOLING DETAILS:

School attended? _____

Address _____

What days does your child attend? _____

Phone: _____

10. NUTRITION:

How does your child eat/drink?

☐ Oral ☐ Nil Orally ☐ Gastrostomy ☐ Naso-Gastric Tube ☐ Combination

---

Oral

Preferred consistency of food: ☐ Pureed ☐ Mashed ☐ Cut ☐ Bottle

Time _____ Food/Drink: _____

Time _____ Food/Drink: _____

Time _____ Food/Drink: _____

Time _____ Food/Drink: _____

Time _____ Food/Drink: _____

Food/Drinks to Avoid _____

Preferred Temperature of Fluids _____

Special Eating Utensils _____

Special Cup/Teat _____

Assistance Required _____

Gastrostomy/Naso Gastric

Type _____ Size _____

☐ Bolus ☐ Continuous ☐ Combination Pump Type _____

Time	Type food/formula/fluid	Amount	Temperature	Rate	Flush Amount

Are there any specific positioning needs at meal times? _____

Any further information to assist us with Button site care i.e. softwick, lotions, dressings etc?

11. SLEEPING:

Usual bedtime? Usual waking time?

Does your child wake during the night? ☐ Yes ☐ No

Preferred sleeping position?

Does your child have a daytime rest? ☐ Yes ☐ No

If yes what times? am pm

Does your child sleep in a ☐ bed ☐ bed with rails ☐ cot

Is there any other information that would be helpful? (i.e. lights on/off; door open/shut; with/without a pillow; favourite toy; music?)

_____

_____

12. HYGIENE NEEDS:

Xavier staff do not cut nails without seeking permission from parents.
Do you give Xavier staff permission to cut/trim your child's nails? ☐ Yes ☐ No

BATHING:

Does your child prefer a bath or shower? _____

Special equipment? (type of chair, bath aide) _____

Any particular fears? (i.e. hair washing, etc) _____

Is there any other relevant information? (i.e. allergic to soap, grommets, etc) _____

_____

MOUTH CARE:
Please provide details of your child's mouth care needs (toothpaste, toothbrush, etc)

_____

TOILETING:
Is your child toilet trained? ☐ Yes ☐ No
Is your child on a toilet training/timing program? ☐ Yes ☐ No
If yes please provide details and specific times.

_____

What types of continence aids are used?

Day _____ Night _____

Does your child require any special equipment or lotions? (e.g. chair, commode, rail, nappy rash cream)

_____

_____

File No. :_____ Child's Name: _____ D.O.B. _____

XAVIER CHILDREN'S SUPPORT NETWORK
Community Team Daily Plan

***To be completed on commencement of supports by Parent/Carer and Support Worker!**

Child's Name:		
Age:	DOB:	Register No:

Environment	In Home	Out of Home
Resources Available in Environment (e.g. toys, community facilities, etc)		

What needs to be done:

Feeding ☐

Sleep ☐

Bathing ☐

Medication ☐

Ideas of things to do.

Contingency	Alternative Arrangements/Things to Do
Poor Weather	
Illness	

Parent's Signature _____ Date: _____