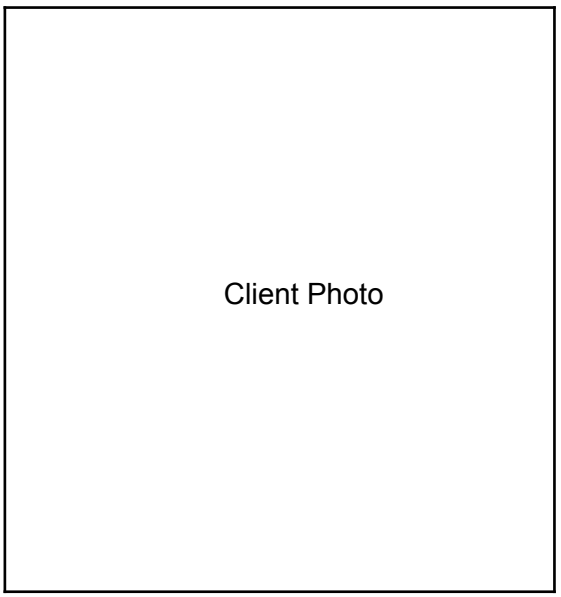
The Clubhouse Project Day Service Limited

Individual Client Support Plan



Name_____

Preferred Name_____

General Information

Personal Details
Date of referral:- …… Source of referral:- …… Client full Name:-…….. Date of Birth:- …./…./……. Address:- …… …… …… Post Code :- ……
Spoken Language:- …….. Religion:- …… Practicing YES/ NO
Allergies:- YES/ NO If yes please specify below:- …… …… ……
Smoker YES / NO Vape YES / NO
Pain management:- Please mark below which pain relief you require and in which form Tablet Effivesant Liquid Paracetamol ☐ ☐ ☐ Ibuprofen ☐ ☐ ☐ Other: Please specify ……..
Medical Practitioner Name:- …… Address of GP:- ……

All personal information records are confidential

…….

Post Code: ……. Phone Number ……..

User Profile

The purpose of the individual client users profile is to learn about the life of the individual. This establishes a good relationship between staff and the individual and can be an important source of information

Diagnosis:

I am prepared to share with people who will be assisting me, information about me including; previous work experiences, social interests, hobbies, leisure pursuits, family background, cultural / religious beliefs. Please provide relevant information in the box below.

Carer and Family contacts and relationships

Please provide next of kin and emergency contact details below

Next Of Kin	**Emergency Contact #2**
Name……..	Name……..
Relationship……..	Relationship……..
Address …… …… …… …… …….. Contact numbers Home…….. Mobile……. Work…… Email ……...	Address …… …… …… …… …….. Contact numbers Home…….. Mobile……. Work…… Email …….

Emergency contact #3	**Emergency Contact #4**
Name……..	Name……..
Relationship……..	Relationship……..
Address …… …… …… …… …….. Contact numbers Home…….. Mobile……. Work…… Email …….	Address …… …… …… …… …….. Contact numbers Home…….. Mobile……. Work…… Email …….

Daily living and needs assessment

1. Personal care and physical wellbeing		**2. Communication**		**3. Mobility and Dexterity**		**4. Personal safety and risk assessment**	
5. Medical History		**6. Medication**		**7. Mental Health And cognition**		**8. Diet and Weight**	
9. Food and Meal times		**10. dental and foot care**		**11. Religious observance**		**12. Daily living and social activities**	
13. Physical Activity		**14. Skin integrity**		**15. Sexuality**		**16.Support Plan User Agreement**	

Personal Care and Physical wellbeing
Is the individual able to perform any of the following unaided? *please circle as appropriate:

Wash	YES / NO	Dress	YES / NO
Put shoes on	YES / NO	Use the toilet	YES / NO
Make a light meal	YES / NO	Make a hot drink	YES / NO
Light house work	YES / NO	Make a cold drink	YES / NO

Please give a written indication of your perception of the individual's ability to care for themselves in addition to the above.

Communication	
Does the individual wear glasses or hearing aid? Please specify:	YES / NO
Is the individual registered as blind? Please specify:	YES / NO
Does the individual require written documents in large print?	YES / NO

Does the individual require written documents in Braille? YES / NO
Is the individual able to hold a conversation? YES / NO Please indicate reasons why conversation or understanding may be impaired e.g - sensory, cognitive or physical impairment.
Are there any aids required to assist with communication? YES / NO Please specify; e.g hearing loop, communication boards, makaton.
Mobility and dexterity
Does the individual have any problems with mobility? YES / NO If yes please specify and record any mobility aids required.
Personal Safety and Risk Assessment Checklist
Please provide from the individuals history any concerns about personal safety and risk including risks of falls, describe your perception of the individuals mobility. It is the duty of care and responsibility of the representative completing this checklist to highlight - Any known risk of harm to self or others - Any known prescribed medication - Assessment / evaluation of issues

RISK FACTOR - Risk to self	LOW	MEDIUM	HIGH
Self-injurious behaviour			
Anti-Social behaviours			
Non-Engagement with staff			
Falls			
Wandering			
Choking			
Mobility on Stairs			
Road sense			
Environmental risks - EG Kitchen or obstacles			
Medical Issues - EG Diabetes, Epilepsy			
Ingesting of substances			
Absconding			
RISK FACTOR - Risk to others			
Violence to family members			
Violence to staff			
Violence to other clients			
Violence to members of the public			
Violence from a third party			
RISK FACTOR - Transport			
Seatbelts			
Opening doors when in transit			
Opening doors into traffic			
Distraction / Interference of Driver			
RISK FACTOR - property			

Arson			
Damage to property			
Theft of property			
RISK FACTOR - Other **- Please specify:**			

Past History and details of any high risk behaviours	
For all high risks identified please provide a description of the risk behaviour - this must include who was involved, circumstances surrounding the incident, the outcome and the chances of a repeat incident.	
Risk identified:	
Date(s) of last occurrence:	
Frequency:	
Who was involved:	
Circumstances:	EG - the capacity to understand the risks and circumstances.
Outcome:	
Chances of a repeat incident:	
Information Provided by:	

Risk Analysis

This should be an objective analysis based on the information above, the views of agencies and professionals involved, the views of the individual and their family and carers

Summary of information received:

Any disagreements:

Risk Management Strategy

Identified Risk	Triggers	Agreed Action Plan	Actioned to	Review Date

Special Precautions:

Medical History

Please specify in as much detail as possible of the individual's medical history

Does the individual require assistance to manage continence? YES / NO
If yes, please specify;

Medication

Does the individual currently take medication? YES / NO If yes, please provide and full list with dosages, frequency and name of medication

Medication	Dosage	Frequency of dose

Does the individual wish to self medicate? YES / NO
Does the individual experience difficulties with self medicating? YES / NO Please specify

Mental Health and Cognition

Does the individual have any problems with mental health or cognition? YES / NO
Please specify;

Behavioural Difficulties

Does the individual require support with the management of their behaviour? YES / NO
If yes, please specify;

Does the individual have any fears or Phobias? YES / NO
Please specify and describe how they react if confronted with the fear / phobia

Diet, nutrition and weight

Does the individual have any problems with their diet or weight? YES / NO
Please specify;

Does the individual have any dietary preferences? YES / NO
Please specify;

Does the individual have any food allergies? YES / NO
Please specify

Food and Meal times

Does the individual require support with eating and drinking? YES / NO
Please Specify

What are the individuals preferred foods?

What foods does the individual dislike?

Dental and Foot Care

Does the individual require assistance with dental or foot care? YES / NO
Please specify; eg wears dentures, suffers from tooth pain, under the care of the chiropodist

Religious Observance

Does the individual require support with practicing their religion? YES / NO
Please Specify

Daily Living and Social Activities

What kind of interests and social activities is the individual interested in? - please list below

Physical Activity

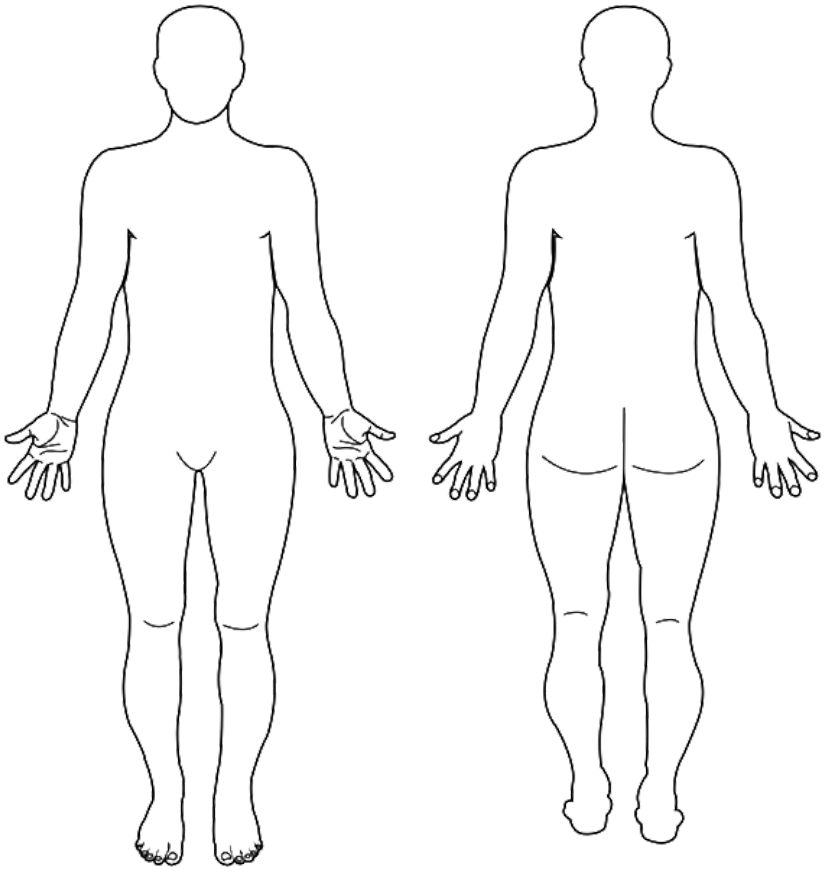
What kind of physical activities is the individual interested in?

Skin Integrity

Does the individual have any skin breaks, bruises or skin conditions YES / NO

If yes please specify;- eg boils, eczema, dry skin, ingrown hairs

Using the body map below please indicate where these skin conditions specified occur using numbers and provide a description of the condition. Overleaf.



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Sexuality

What is the individual's sexuality?

Straight Gay Lesbian Bi Sexual Other…….

How does the individual identify?

Male Female Nonbinary Transgender Other…….

Please specify the individual's preferred pronouns below;

He/Him She/Her They/Them Other …….

Is there any information or support staff can provide to assist the individual in expressing their sexuality? YES / NO
Please specify:

How does the individual express their sexuality?
Eg; LGBTQ+ badges, types of clothing, make up, accessories

Support Plan User Agreement		
Individuals Name:		
Our Agreement With You		
We agree to provide the services, care and support stated in the objectives of your individual client support plan using the information you have provided		
Client and / or Representative Agreement		
I have completed and read the contents of my support plan and agree with the services and supports that if provided for me YES / NO		
I have completed and read the content of the individual's support plan and agree with the services and support provided for the individual I represent. YES / NO		
Individuals signature:		Date:…….
Representative Signature:	Relation to individual: ……....	Date:……..