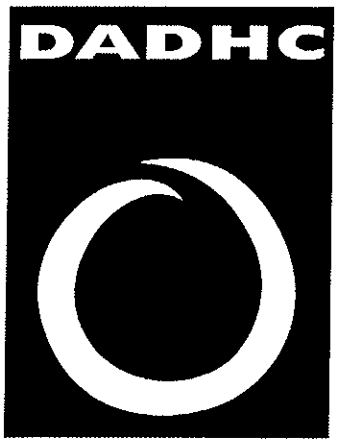

Department of Ageing, Disability & Home Care

ORIENTATION TO RESPITE SERVICES:
Respite Plan

Issued 2002
Updated June 2006

1. CLIENT PROFILE

Client Name		
Date of Birth		Insert photograph here
Sex		
Height		
Weight		
Eye colour		
Hair colour		
Phone No		
Address		
Distinguishing features		
Primary disability group (see Intake form):		
Other significant disability (see Intake form):		
Other significant conditions (eg asthma, diabetes, allergies):		
Country of birth		
Aboriginal	☐ Yes ☐ No	**Torres Strait Islander?** ☐ Yes ☐ No
Ethnicity		
Religion		
Language(s) spoken at home		
Language(s) spoken		
Interpreter required?		
Pension number		
Medicare number		
Known allergies		
Private Health Insurance details		
Under what circumstances would you like to be contacted[1] and when? (Eg: If client fell over and bruised their leg, contact immediately or on pick up?)		

[1] In the case of emergencies, you will be contacted immediately.

Emergency contact	
Name	
Address	
Relationship to client	
Telephone Home:	
Mobile:	

2. FAMILY AND SOCIAL SITUATION

	Mother	Father
Name		
Country of birth		
Language		
Interpreter required?		
Assistance required filling out forms?		
Siblings (Name, age, relationship)	1/ 2/ 3/	
Current living situation	☐ With family ☐ With others	
Please name other persons that are living in the client's home		
Any other persons in close contact with the client? Eg. Friends, relatives		
Other emergency contact person if family not available		
Have you been informed that you may phone and talk to the client whilst they are in respite?	☐ Yes ☐ No	

How does the client fit into new groups?	
Does the client make friends easily?	
How has the client reacted in the past when they have stayed away from home? (Ie. In other respite or temporary care)	
Does the client have any special religious and cultural issues/practices? Eg. Fasting, diet, attendance at services etc.	
How does the client feel about staying at the respite centre?	

3. COMMUNICATION

What methods of communication does the client use? (See Intake form)		
How does the client communicate...?		
Thirst		
Hunger		
Anger		
Sadness		
Happiness		
Other needs		
How does the client indicate a preference?		
Does the client understand others if they use...?		
Speech:	☐ Yes ☐ No	
Sign:	☐ Yes ☐ No	
Gestures	☐ Yes ☐ No	
Please comment on the client's ability to use...		
Telephone:		
Reading:		
Writing:		
Is there anyone or anything they like to talk about? (Eg people, pets, toys, places)		
Does the client use a communication aid?	☐ Yes ☐ No	
Does the client have a communication plan? (If yes, please attach copy of plan).	☐ Yes ☐ No	

4. MOVEMENT AND MOBILITY

Please describe the clients level of mobility (eg fully mobile, slight physical disability, needs assistance to walk, uses wheelchair for mobility uses other aids) **and attach manual handling plan** (if required)	
Has the client any difficulty with vision or hearing?	☐ Yes ☐ No
If yes, please describe:	
Does the client require special seating while travelling in a vehicle?	☐ Yes ☐ No
If yes, please describe	
Does the client find it difficult to move on rough or uneven ground?	☐ Yes ☐ No
Please describe if there any other issues regarding the client's movement or mobility:	
Does the client require any special aids? (Eg. Glasses, walking frame, wheelchair, orthotics, splints, helmets etc)	

5. NUTRITION AND SWALLOWING

Has a nutrition and swallowing checklist been completed? (If yes, please attach copy of checklist)	☐Yes ☐No
On what date was the checklist completed?	
Were there risks identified? (If yes, please attach copy of Eating and drinking/Mealtime management plan)	☐Yes ☐No

6. CLIENT RISK PROFILE

Does the client have a completed Client Risk Profile[2]? (If yes, please attach. If no, complete prior to first orientation stay)	☐Yes ☐No

[2] To be issued with *Managing Risks and Incidents* policy

7. SUPPORT PLANS

(Please refer to needs assessment)

Does the client have any Health Issues? (Please attach a copy of the Health Care plan)	☐Yes ☐No
Does the client take medication? (Please attach a copy of the Medication Management plan)	☐Yes ☐No
Are there any safety issues? (Please attach a copy of the Client Risk Profile and appropriate plans: eg Epilepsy Management Plan)	☐Yes ☐ No
Are there any Behavioural issues? (Please attach a copy of the Incident Prevention and Response, Behaviour Intervention and Support and/or Informal management plans {eg for self-stimulatory/stereotypical behaviour})	☐Yes ☐ No

8. SKILLS AND PARTICIPATION

8.1 Eating and Drinking

Client's usual meals – time and content

MEALS	TIME	CONTENT
Breakfast		
Morning Tea		
Lunch		
Afternoon Tea		
Dinner		
Supper		
Is the client on a special diet? (If yes, please give details)		☐Yes ☐ No
Special <u>likes</u> in food and drinks:		
Special <u>dislikes</u> in food and drinks:		

8.2 Dressing

Can the client dress themselves?	☐ Yes ☐ No
If yes, what can they do and what level of assistance is required?	
Can they manage buttons, zippers, etc?	☐ Yes ☐ No

8.3 Bed routine

Has the client ever slept away from home before?	☐ Yes ☐ No
Does the client have problems sleeping away from home?	☐ Yes ☐ No
Does the client sleep with the light on?	☐ Yes ☐ No
Does the client sleep with the bedroom door closed?	☐ Yes ☐ No
Do they sleep in a single room at home?	☐ Yes ☐ No
Does the client wear a pad/nappy to bed?	☐ Yes ☐ No
Does the client need to be repositioned during the night?	☐ Yes ☐ No
If yes, how frequently?	
What is their usual bedtime and routine? Bath, supper, etc.	
Are there any special sleeping needs? (Eg. two pillows, cot sides etc)	
How does the client indicate that they want to go to bed?	
Does the client usually sleep throughout the night?	☐ Yes ☐ No
If not, what is the usual sleeping pattern:	
Is the client toileted during the night?	☐ Yes ☐ No
If yes, what times?	
Is there any other information regarding the client's sleeping needs?	

8.4 Bathing and grooming

Does the client prefer bath or shower?	
What time does the client usually bathe?	
Is the client aware of the dangers of hot water?	☐Yes ☐ No
What assistance does the client require to...?	
Fill a bath or run a shower?	
Clean teeth?	
Shave?	
Wash hair?	
Wash hands?	
Clean their nose?	
Does the client use any special soap/shampoo/bath oil?	☐Yes ☐ No
If yes, please give details:	
Does the client need to be supervised while bathing? (If client has epilepsy, the answer must be yes)	☐Yes ☐ No
If yes, please give details	

8.5 Management of Menstruation

What sanitary products does the client use?	
What level of assistance does the client require?	
What is the usual duration of menses?	
Usual flow?	
Usual pain relief?	
How does the client indicate pain?	

8.6 Toileting

Is the client fully independent with toileting? (If YES go to 'section 8.7')	☐Yes ☐ No
If NO please answer the following questions	
Is the client aware of the need to use the toilet?	☐Yes ☐ No
If YES how does the client indicate this need?	
What is the daytime toileting routine?	
Night-time toileting pattern?	
Is the client toilet timed?	☐Yes ☐ No
If YES, at what times?	
Does the client have a particular routine concerning bowel movements?	☐Yes ☐ No
If YES, please give details:	
Does the client have a problem with constipation? (If yes, please answer following three questions)	☐Yes ☐ No
How is this treated?	
Is this prescribed by a Doctor?	
Are there signs, symptoms or behaviour changes that may indicate the client is constipated?	
What level of assistance is required in the use of toilet paper?	
Does the client require the use of special aids or appliances (eg nappies, urodome etc)?	☐Yes ☐ No
If YES, please give details:	
Can the client distinguish Public Toilet signs – Male/Female?	☐Yes ☐ No
Are there any preferred ways of toileting (eg males sitting to urinate, using a commode etc)?	☐Yes ☐ No
If YES, please give details:	

8.7 Social Skills

How does the client relate to peers?	
Does the client prefer to interact with children, adults or both?	

9. COMMUNITY ACCESS

COMMUNITY ACCESS / RECREATION OUTINGS / TRANSPORT PLAN

Date plan developed:		**Review date:**	
Client's name:		**CIS ID**	
Do you wish for your son/daughter to participate in community access /recreation outings whilst in respite?			☐Yes ☐No
If yes, what type of activities does your son/daughter enjoy/dislike? Please list:			
Likes / preferred activities		Dislikes	
Are there any activities that the client cannot participate in due to medical reasons? (Eg, trampoline, gymnastics).			☐Yes ☐No
If yes, please list			
Are there any activities that the family/carer do not wish the client to participate in?			☐Yes ☐No
If yes, please list			
Do any of the following factors affect the client?			
☐ Noises (Please list)		☐Animals. (Please list)	
☐Crowds		☐Fire works	

Does the client require wheelchair access into a venue?	☐Yes ☐No
Can the client walk on uneven surfaces?	☐Yes ☐No
Is the client aware of Road Safety?	☐Yes ☐No
Is the client aware of Stranger Danger?	☐Yes ☐No
Does the client wander off/abscond?	☐Yes ☐No
Can the client go out in a small group with staff support?	☐Yes ☐No
Does the client require 1:1 staff support on outings?	☐Yes ☐No
Can the client attend community access outings without staff support?	☐Yes ☐No
If yes, please list activities (eg, walk to shops).	
Does the client remain seated whilst travelling in a vehicle?	☐Yes ☐No
Does the client remove their seat belt whilst travelling?	☐Yes ☐No
Does client require activities whilst travelling (eg, books, music)?	☐Yes ☐No
If yes, please list suggestions	
Recommended maximum travelling time?	_____ HOURS _____ MINUTES
Does the client have any preferred seating arrangements in a bus (eg, on own, back seat)?	☐Yes ☐No
If yes, please list:	
Is the client able to travel on public transport with staff support?	☐Yes ☐No
If yes, what forms of transport?	
☐Taxi	☐Public bus
☐Train/tram	☐Ferry/boat
Does the client show warning signs of potential behaviour difficulties whilst on outings?	☐Yes ☐No
If yes, what are these signs?	
Does the client have a behaviour plan/reactive strategy? (If yes, please attach and staff to check plan prior to outings)	☐Yes ☐No
Is the client able to look after their own pocket money on outings?	☐Yes ☐No
Do you want the client to participate in outings that involve water sports / swimming?	☐Yes ☐No

Can the client swim independently?	☐Yes ☐No
Does the client require 1:1 support whilst in water?	☐ Yes ☐No
Does the client prefer beach or still water (eg pool)?	
Does the client require wheelchair access to the pool and into the pool?	☐Yes ☐No

I _____ (client / parent / carer / guardian) understand that _____ _____(client's name) can participate in community access / recreation outings / transport outings in line with the information provided above.

SIGNED: _____
DATED: _____

10. SCHOOL, WORK, DAY PROGRAMS AND OTHER RESPITE,

10.1 School/Work/Day Programs

Does the client attend school, work or day programs?	☐Yes ☐ No
Name	
Address	
Phone No.	
What are the hours of attendance?	
Is there any other information regarding day placement, that staff need to be informed of during their stay? (Eg. sports days, lunch provided on certain days, etc)	
Is transport provided for school/work/day placement?	☐Yes ☐no
If yes, with whom? (Include contact details)	

10.2. Other respite services

Are other Respite services used?	☐Yes ☐No
If yes, which one(s)?	

How often are they used?	

11. OTHER ISSUES/INFORMATION

Are there any other issues or information we require to ensure that the client has a positive experience in respite?

12. AGREEMENTS

Letter Opening / Reading of Communication Book

I, _____ (Name of parent/ carer / guardian) give permission for the staff of the respite service to open and read any letters and/or communication books sent in my son / daughter's bag from his day placement / school whilst he/she is staying at the respite service

I place the following restrictions on my permission: _____
_____.

Seek Emergency Medical Treatment

I, _____ (Name of parent/ carer / guardian) understand that substitute consent is not required for medical treatment if, in the opinion of the practitioner, treatment is necessary as a matter of urgency to:

- Save a persons life
- Prevent serious damage to a person's health
- Alleviate significant pain or distress

I understand I will be contacted as soon as possible by the respite service staff. I agree to pay the cost of any medical attention received.

SIGNED: _____ DATE: _____

Photography

I, _____ (Name of parent/ carer / guardian) hereby give permission for the staff of the respite service to film / photograph my son / daughter whilst he/she is staying in at the respite service.

I understand these photographs will be used for identification purposes and to assist the client in programs identified in their respite care plan.

I place the following restrictions on my permission: _____
_____.

I understand that this permission is only valid for a period of 12 months.

SIGNED: _____ DATE: _____

NB: *I understand that I can withdraw my permission at any time.*

Department of Ageing, Disability & Home Care

ORIENTATION TO RESPITE SERVICES: Prioritisation Criteria for the Allocation of Planned Respite

(Adapted from policy: *Allocation and Prioritisation)*

For use by the Allocation Panel in determining the allocation of planned respite.

IMMEDIATE RESPONSE (1):

- Violence or abuse resulting in the client, family or carer, or member of the community being at risk of injury.
- Clients displaying challenging behaviour such that they are at risk of becoming involved in the Juvenile or Criminal Justice System or who have already been involved with the Criminal Justice System and are at risk of re-offending.
- A client is at imminent risk of entering a more restrictive option and/or whose carer is likely to be at risk unless entry into the service is facilitated. This may include clients who are at risk of incarceration or re-incarceration. It may also apply to young people who have been or are at risk of being inappropriately placed in an aged care nursing home.
- A child or young person known to the Department of Community Services (DOCS) where any of the following apply:
    - child aged 7 or over or young person was given a Helpline initial assessment of high risk, or
    - child aged 7 or over or young person assessed as "at risk of harm" by the DoCS Caseworker in the field.
- An adult client has been subjected to abuse.
- There is a life-threatening risk to the client's health or they are experiencing a serious deterioration in health.[1]

HIGH NEED FOR RESPONSE (2):

[1] This condition only applies to the Grosvenor Centre.

- The current support arrangements, including any temporary arrangements in place, have suddenly changed or are at risk of changing and require action to enable them to be resumed or maintained.

- The age of the primary carer/s is over 65 years (50 years for Aboriginal or Torres Straight Islanders).

- The health of the primary carer is placing the client, family or carer at risk.

- Lack of support network for carer is impacting on the carer and/or client (eg single parent is sole carer for the client and has moved to a new Area).

- Geographical isolation is impacting on the ability of the carer to maintain that role.

- Social isolation is impacting on the client and carer.

- DoCS have made a request for a service for a child or young person in situations **other than** those specified above (see Part 3 Section 17 & 18, Child and Young Person (Care and Protection Act) 1998, and Intake Policy Section 1.1 and Forms IF5 and IF6).

- No other service available in the Region/Area **and** has been waiting for a service for over 6 months.

MEDIUM NEED FOR RESPONSE (3):

- Have been waiting for a service for 2 months.

LOW NEED FOR RESPONSE (4):

- Less than 2 months on the Service Request Register.

ALLOCATION CRITERIA FOR DAY STAYS:

(The following are the only criteria by which planned day stays may be allocated)

- The age of the primary carer/s is over 65 years (50 years for Aboriginal or Torres Straight Islanders).

- The health of the primary carer is placing the client, family or carer at risk.

Department of Ageing, Disability & Home Care

ORIENTATION TO RESPITE SERVICES: Request Form

(Bookings Form)

FOR PERIOD: _____ **TO** _____

Client's name:			
Date of birth:		**Gender**	☐M ☐F
Address:			
Respite user phone (h)		**Respite user phone(w)**	
Is the client receiving respite from any other services?		☐Yes ☐No	
If yes, please provide details:			
Name of Respite service	Respite Service type provided	Hours per month	
Does the client attend school / day placement?		☐ Yes ☐No	
Name:		**Phone:**	
Is the school a residential school?		☐ Yes ☐ No	
Number of days per week that client attends day placement?			
Number of hours per day?	**Start time**	**Finish time**	
Preferred respite unit:			

RESPITE REQUESTED

Number of Mid Weeks		**Number of weekends**		**Number of stays in school holidays**	

Please complete with numbers (above) OR dates (below)

Mid Weeks		**Weekends**		**School holidays**	
Arrival	Departure	Arrival	Departure	Arrival	Departure

The Respite Allocation Panel meets on .....and will consider all requests for DADHC Planned Center Based Respite.

REASONS FOR REQUESTING RESPITE FOR THIS PERIOD

FAMILY NEEDS:

For example, ageing carers, illness in family, lack of other support, issues with other children in the family, sole parent, work or social commitments,

Please comment: -_____

_____

_____

_____

_____

_____

_____

CLIENT NEEDS:

List the client's support needs: for example, Health Issues, High Physical Support Needs, Challenging Behaviour, Communication etc. (Details to be provided in Respite Care Plan update form).

_____

_____

_____

_____

_____

_____

Please attach any further relevant information regarding reasons for requesting respite and an updated respite plan for this respite period.

Information provided by: _____ **Relationship to client:** _____

Date: _____

DADHC RESPITE SERVICES – SPECIAL REQUEST FORM

FOR PERIOD: _____ TO _____

SECTION 1: Only complete this section if not submitting the request form on page 1			
Client's name:			
Date of birth:		**Gender**	☐M ☐F
Address:			
Respite user phone (h)		**Respite user phone(w)**	
Is the client receiving respite from any other services?			☐Yes ☐No
If yes, please provide details:			
Name of respite service	Respite service type provided	Hours per month	
Does the client attend school / day placement?			☐ Yes ☐No
Name:		**Phone:**	

SECTION 2 (this section must be completed for all special requests)			
Preferred respite unit			
Dates and reason service is being requested			
Date (from – to)	**Arrival**	**Departure**	**Reason**

SECTION 3 (To be completed by Respite Client Liaison Officer)	
Has the respite user made a special request / request for booked holiday in the past 12 months?	☐ Yes ☐ No
If yes, what dates were allocated:	

Date (from – to)	**Arrival**	**Departure**

Department of Ageing, Disability & Home Care

ALLOCATION OF PLANNED RESPITE: Respite Booking

{Unit Name}
{Unit Street Address}
{Unit Mail Address}
{Unit Phone Number}

{Name}
{Address}
{Date}

Dear

Respite Booking

Please find enclosed DADHC Respite Services – Request Form (booking form) for the period _____ to _____. As you are aware regular allocation meetings are held 4 times each year.

Please note that requests for care beyond the date stated above (e.g. planned surgery in 5 months time) must be made separately in writing to the Client Respite Liaison Officer.

If you would like assistance to complete these forms please do not hesitate to contact your Case Manager from the Community Access Team or your respite Key Worker.

The request forms are required for planning and allocation by the _____. Please return your forms to _____ at _____
_____

Thank you,

Yours sincerely

{Name}
Respite Client Liaison Officer
CC: Case Manager, Key Worker

Place local contact details here.