

RESTORATIVE SUPPORT

IS IT PERSONAL CARE AND HOUSEHOLD MANAGEMENT BY ANOTHER NAME?

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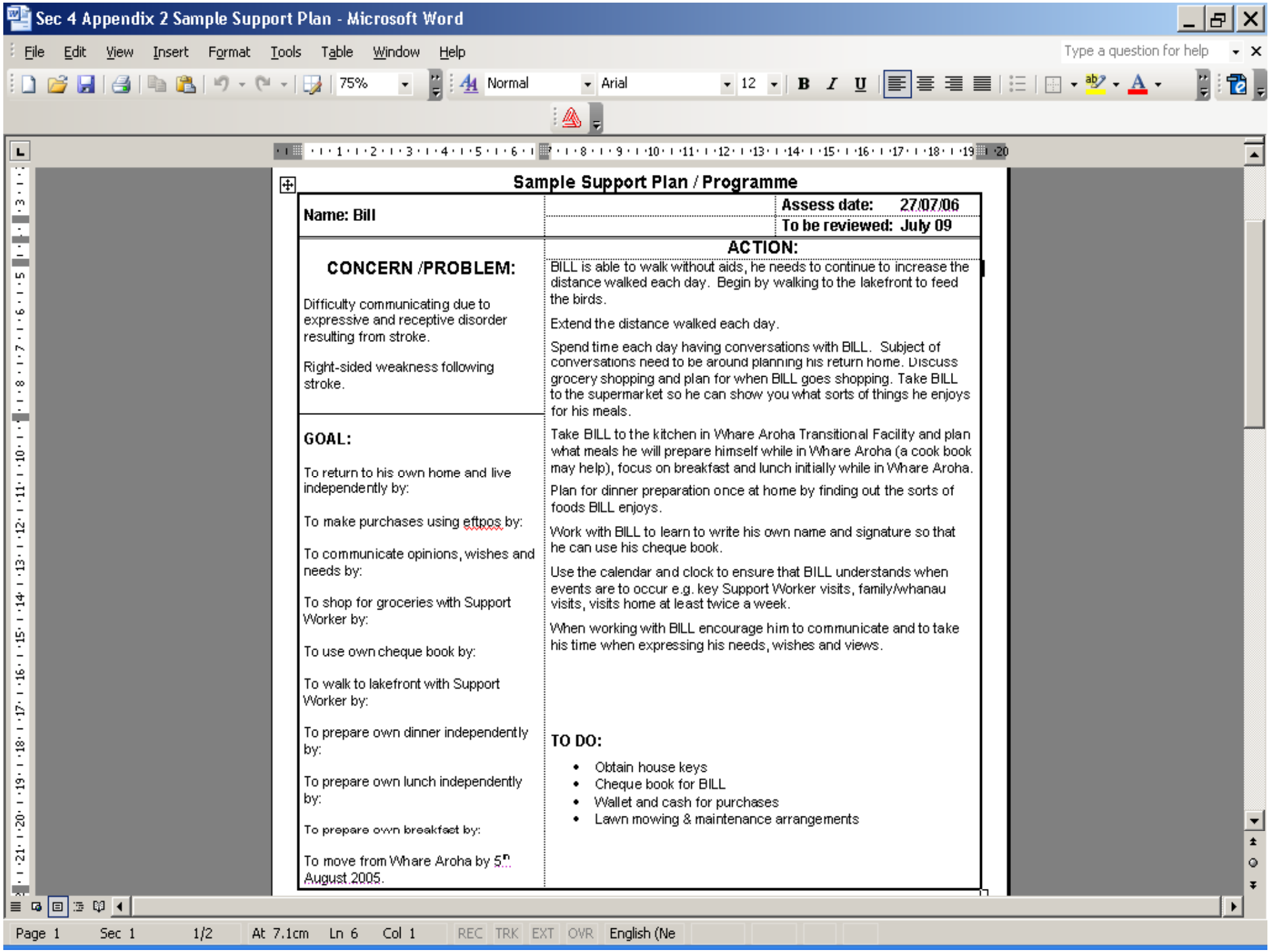
enliven Positive Ageing Services


Sec 4 Appendix 2 Sample Support Plan - Microsoft Word
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Sample Support Plan / Programme
Name: Bill
Assess date: 27/07/06
To be reviewed: July 09
CONCERN /PROBLEM:
Difficulty communicating due to expressive and receptive disorder resulting from stroke.
Right-sided weakness following stroke.
GOAL:
To return to his own home and live independently by:
To make purchases using eftpos by:
To communicate opinions, wishes and needs by:
To shop for groceries with Support Worker by:
To use own cheque book by:
To walk to lakefront with Support Worker by:
To prepare own dinner independently by:
To prepare own lunch independently by:
To prepare own breakfast by:
To move from Whare Aroha by 5th August 2005.
ACTION:
BILL is able to walk without aids, he needs to continue to increase the distance walked each day. Begin by walking to the lakefront to feed the birds.
Extend the distance walked each day.
Spend time each day having conversations with BILL. Subject of conversations need to be around planning his return home. Discuss grocery shopping and plan for when BILL goes shopping. Take BILL to the supermarket so he can show you what sorts of things he enjoys for his meals.
Take BILL to the kitchen in Whare Aroha Transitional Facility and plan what meals he will prepare himself while in Whare Aroha (a cook book may help), focus on breakfast and lunch initially while in Whare Aroha.
Plan for dinner preparation once at home by finding out the sorts of foods BILL enjoys.
Work with BILL to learn to write his own name and signature so that he can use his cheque book.
Use the calendar and clock to ensure that BILL understands when events are to occur e.g. key Support Worker visits, family/whanau visits, visits home at least twice a week.
When working with BILL encourage him to communicate and to take his time when expressing his needs, wishes and views.
TO DO:
Obtain house keys
Cheque book for BILL
Wallet and cash for purchases
Lawn mowing & maintenance arrangements
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GOAL (Must include date to be achieved)

MARY wants to be able to shop independently, prepare lunch and cook lunch independently for her Ma-jong group by 1st August 2005.

For this, MARY needs to be able to wash and dress independently by 1st July

MARY needs to be able to prepare meals independently by 1st July.

Aim for discharge on 1st September and commence D process on 1st August

Current difficulties

MARY had a stroke in April 2004 and has been left with left sided weakness and when she becomes tired can find it hard talking and letting you know what she wants to say.

PLAN (please integrate exercises and household tasks)

1. MARY can wash and dress herself but needs help **ONLY** with buttons.
2. MARY can open curtains herself, please stand beside her as she opens them. Practice opening and closing them five times.
3. MARY can vacuum clean herself (Tuesday) and sweep the floors (Wednesday), please stand behind her as she does this.
4. MARY is awaiting an OT assessment, but can not at present prepare vegetables. Under her guidance, prepare vegetables and place in steamer for her evening meal.
5. Whilst in kitchen, place two cans in shopping bag and encourage MARY to practice lifting bag from floor to work bench as many times as she can before she gets tired (record in notes how many times and add on 1 lift every day).
6. MARY uses a treadmill daily, but on a fine day, walk with her as far as she can manage along road (MARY uses a stick) record in notes where she walked to and aim to increase the distance the next visit.
7. If it is raining outside, practice standing from dining room chair a minimum of ten times (record in notes and build on from previous visit).
8. Every two weeks (see roster) take MARY to Countdown with walking stick and whilst in shop, MARY holds onto and pushes trolley. She needs to take items off shelves herself.
9. MARY may become tired and when she does, she may find it harder to talk clearly (give her time and cut down on back ground noise as much as possible).

To do list:

- OT assessment for meal preparation and dressing
- Shift bed away from curtains
- Referral for Tai Chi
- Information on Fatigue Management
- Back scrubber

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Sample Description

- Fifty clients
- 16 had Complex Packages of Care – ranging from 6 units to 46 units
- 34 had Non Complex Packages of Care – ranging from 2 units to 28 units

16 Complex Clients

- The distal goal was set for 13/16 Complex clients. The remaining 3 had a goal documented in the support plan
- 9 out of 16 Complex clients had an action in the support plan related to the goal
- 4 out of 16 had an exercise programme – 100% of these clients had a related action in the support plan and 3 out of the 4 had documented support worker notes describing the exercise plan actually taking place

34 Non Complex Clients

- The Distal goal was set for 25 of the 34 Non Complex clients. The remaining 9 had a goal documented in the support plan
- 8 out of the 34 clients had an action in the support plan related to the goal
- 8 out of 34 had a documented exercise programme. This was reflected in 4 support plans

Relationship between goal and action described in the support plan

	Total Number	Distal Goal Set	Support Plan Goal only	Goal Related to Action Plan	% of Action related to goal
Complex	16	13	3	9	56%
Non Complex	34	25	9	8	23%

Impact of the type of goal set

Goals should be SMART:

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- Specific

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- Specific
- Measurable

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Goals should be SMART:

- Specific
- Measurable
- Achievable

Impact of the type of goal set

Goals should be SMART:

- Specific
- Measurable
- Achievable
- Realistic

Impact of the type of goal set

Goals should be SMART:

- Specific
- Measurable
- Achievable
- Realistic
- Time related

Specific V Non Specific goals

- Wanted to see if the type of goal had an impact on the documentation cascade from the Distal goal to the Support worker notes
- There were some limitations in analysing this data as we did not have a full set of Support Worker documentation.
- The other limitation is nature of non specific goals– tended to be wide sweeping ie to stay at home, therefore achieving the goal may be related to a wide range of factors
- Example of a non specific goal – Maintain independence
- Example of a specific goal – Return to bowls in 3 months

Impact of type of goal set

	Goal related to action	Goal achieved	Goal not achieved	Total
Specific Goal	7 (30%)	5 (22%)	15/23 DK 3/23 No	23
Non Specific Goal	9 (35%)	6 (23%)	17/26 DK 1 /26 Partially	26

Does size of Package of Care impact on Goals relationship to Action Plan?

	Action Plan related to goal - yes	Action Plan related to goal - DK	Action Plan related to goal - no	Total
Complex POC smaller than 15 units	4 (100%)	0	0	4
Complex POC larger than 15 units	7 (54%)	2 (15%)	4 (31%)	13
Non Complex POC smaller than 6 units	4 (20%)	0	16 (80%)	20
Non Complex POC larger than 6 units	4 (31%)	0	9 (69%)	13

Conclusions

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- The action plan for the support worker is more likely to be related to the set goal if the package of care is complex. Possible reasons for this are: Need is more identifiable, more time is available, client more motivated

- For complex clients the size of the package does not appear to make a difference regarding the connection between the goal and the action plan.

Conclusions

- Small Non Complex packages of care are the least likely to have a connection between the goal and the action plan – the action plan for the support worker was most likely to be a list of household management tasks closely resembling the type of list produced for a traditional community support client. Possible reasons: more focused on household management, higher level of skill to set SMART goal, priority for clinician not as great

Conclusions

- Small Non Complex packages of care are the least likely to have a connection between the goal and the action plan – the action plan for the support worker was most likely to be a list of household management tasks closely resembling the type of list produce for a traditional community support client.

- A documented exercise plan was more likely to be described in the action plan and therefore more likely to be carry out if the package of care was complex . Only 50 % of exercise programs planned for Non Complex clients were described in the action plan compared to 100% description for Complex clients.

Questions?

- Coordinator training? TARGET / Goal setting
- Support worker training?