DRAFT Residential Aged Care
ADL Care Plan

SMR000000

Residents' Photograph Ensure date and Resident Name on front of photo	**Date:**
	Name:
	Preferred Name:
	Unit: **Room:**
	D.O.A.: **DOB:**
	Doctor:
	Diagnosis:

Social History Summary:

COMMUNICATION/COMPREHENSION

Hearing: **Aid/s:**

Sight: **Aid/s:**

Speech: (Include languages spoken)

Comprehension/Awareness: AMTS **done: Yes / No** **If Yes – score:**

Strategies to Assist with Communication:

Written By: (Print)________________Signature:______________Des'g:__________Date:_______

xxx0000 000000

Health
Western NSW
Local Health District

Facility:

DRAFT Residential Aged Care ADL Care Plan

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Mobility:	Name: ______________
	D.O.B.: ____________ Room: ________
Transfers:	Or Attach Bradma
	Seating:
Bed Mobility:	

ACTIVITIES of DAILY LIVING

Assistance Required:

Hygiene:	**Oral Care:**
Prefers: Shower / Bath	
Preferred Time:	
Frequency of Shower/Bath:	
Uses:	
Hair:	**Podiatry:**
Wash Hair:	
Uses:	**Skin Integrity:**
Hairdressing:	
Finger Nails:	
Shave/Make-up:	
Personal Accessories:	

Preferred Day Wear:	**Preferred Night Wear:**

NUTRITION & HYDRATION

Frequency of Weighing:

FOOD ALLERGIES:

Assistance Required:

Special Considerations/Cultural Issues:

Diet:	**Fluids:**
Aid:	**Aid:**
Likes:	**Dislikes:**

Written By: (Print)________________ Signature:______________ Des'g:__________ Date:________

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

GWA000000

NO WRITING

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Western NSW
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / ______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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CONTINENCE MANAGEMENT

Assessment Date:	Name: ______________________
Nursing Diagnosis:	D.O.B.: ____________ Room: __________ *Or Attach Bradma*

Assistance for Toileting:

Urinary Management:	**Bowel Management:**
Highlight toileting times in BLUE	Highlight times for Bowel in YELLOW

A.M.	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200
P.M.	1300	1400	1530	1600	1700	1800	1900	2030	2100	2200	2300	2400

Aid in am::		Aid in pm:		Aid at night:	

Please Note:

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SLEEP

Gets up at::	Strategies to Assist Sleep:
Retires at:	
Aids Required:	

MEDICATION:

ALLERGIES: **Refer to Medication Chart**

TECHNICAL or SPECIALISED NURSING

Skin Integrity: Waterlow Scale: Date: Risk Rating:

SPECIALISED CARE PLANS ATTACHED

Restraint Management		PEG Tube/Feed		Pain Management	
Indwelling Catheter		Supra-Pubic Catheter		Diabetes Manage't	
Physiotherapy		Oxygen Therapy:		Behaviours	
Colostomy/Ileostomy Mgt		Pressure Area Care		Protective Bandaging	
Oedema/Lymphoedema		Skin Condition/Rashes			

Specify if Other:

Written By: (Print)________________Signature:______________Des'g:__________Date:________

XXX0000 000000

NO WRITING