Individual Care Plan for Residents in Residential Care Homes for the Elderly

(RCHE should formulate the individual care plan (ICP) within 1 month after admission and conduct the first review in 6 months. RCHE should also review the ICP at least annually)

Part I: Particulars of Resident

Name	Sex/Age	HKIC no.	Room and/or bed no.
Body weight (kg)	Height (m)	Body mass Index (BMI = weight/height^2)	Date of assessment

Part II: Risk Factors

Item	Content	Remarks (if applicable)
Swallowing difficulty	☐Nil ☐Yes If yes: ☐Soft meal ☐Minced ☐Pureed ☐Use of thickeners ☐Use of feeding tubes: *nasogastric tubes and percutaneous endoscopic gastrostomy feeding tubes	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____
Falls	Number of falls within the past 6 months ☐Nil ☐Yes:_____times	☐Limb strength assessment/training is recommended ☐Balance assessment/training is recommended ☐Others:_____
Wandering	Number of wandering within the past 6 months ☐Nil ☐Yes:_____times	☐Carry out anti-wandering measures ☐Others:_____
Cognitive impairment	☐Nil ☐Yes (diagnosed by doctor) If yes: ☐Mild ☐Moderate ☐Severe	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____
Emotion performance	Overall emotion performance within the past 3 months: ☐Peaceful ☐Depressed ☐Manic ☐Anxious ☐Panic ☐Paranoid ☐Others:_____	☐Performance is similar as before ☐Performance is different from before →☐No follow-up is required →☐Referral for professional intervention →☐Others:_____
Behavioural problems	☐Nil ☐Yes If yes, please specify:_____	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____

Item	Content	Remarks (if applicable)
Allergies	☐Nil ☐Yes If yes: ☐food ☐drugs ☐others_____	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____
Others		

Part III: Functional Assessment (please refer to medical examination form)

Medical history (please specify)				
Mental state	☐ Normal/Alert/ Stable	☐ Mildly disturbed	☐ Moderately disturbed	☐ Seriously disturbed
Mobility	☐ Independent	☐ Self-ambulatory with walking aid or wheelchair	☐ Always need assistance of other people	☐ Bedridden
A.D.L.	☐ **Independent** (No supervision or assistance needed in all daily living activities, including bathing, dressing, toileting, transfer, urinary and faecal continence and feeding.) ☐ **Occasional assistance** (Need assistance in bathing and supervision or assistance in other daily living activities.) ☐ **Frequent assistance** (Need supervision or assistance in bathing and no more than 4 other daily living activities.) ☐ **Totally dependent** (Need assistance in all daily living activities)			

Pat IV: Assessment on the Needs of Personal Care

Item	Content	Remarks (if applicable)
1. Nursing Care		
Nursing care	☐Nil ☐Yes If yes, please specify ☐Incontinence ☐No ☐Yes ☐Wound ☐No ☐Yes (location:) ☐Pressure injury ☐No ☐Yes (location:) ☐Use of catheters ☐No ☐Yes ☐Use of feeding tubes ☐No ☐Yes ☐Peritoneal dialysis ☐No ☐Yes ☐oral cavity ☐No ☐Yes ☐Others: _____	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____
2. Social Care		
Interests/ hobbies	☐Travelling ☐Music ☐Drawing/Calligraphy ☐Reading ☐Mahjong playing ☐TV/Movies ☐Gardening ☐Doing handcrafts ☐Mass activities/games ☐Others:	☐Referral for medical follow-up is recommended ☐Referral to doctor has been made ☐Others:_____

Item	Content	Remarks (if applicable)
Supportive network	☐Without relatives and/or friends ☐With relatives and/or friends If having relatives and/or friends, please specify: visits by relatives and/or friends ☐Nil ☐Yes (no. of visits per month:___) outings with relatives and/or friends/home leave ☐Nil ☐Yes (no. of outings/home leave per month:___)	
Social participation	☐Actively participating in activities and/or talking to others ☐Occasionally or passively participating in activities and/or talking to others ☐Unwilling and never participate in activities and/or talk to others ☐Unable to participate in activities and/or talk to others	☐Similar pattern as before ☐More sociable ☐Less sociable →☐Follow-up is required
Others		

Part V: Other Professionals' Comment (e.g. social workers, occupational therapists, physiotherapists, speech therapists, etc.)

1.	
2.	
3.	
4.	

Part VI: Case Conference

Date of Conference: / / (dd/mm/yyyy)		
Attendants	Staff (Name)	☐Home manager ( ) ☐Nurse ( ) ☐Health worker ( ) ☐Care worker ( ) ☐Others (name & rank:)
	Resident	☐Present ☐Absent, reason:
	Family members	☐Present (Name & relationship:) ☐Absent, reason: →☐contact the family member after conference (Date, name & relationship:)
Comment of resident/ family members	☐Agree to the care plan ☐Other comments:	

Part VII: Care Plan/Regular Review

1. Complete this part when formulation of the care plan (Date: / /)(dd/mm/yyyy)	
Caring/ rehabilitation need of the resident	
Goals/ expected outcome	
Service plan/ strategies	
Date of review	

2. Complete this part when reviewing of the care plan	
Date of review	
Respective staff	Name: Rank:
Outcome	
Next review date	

Signature of nurse/health worker	Name of nurse/health worker	Date
Signature of home manager	Name of home manager	Date