Individual Care Plan for Residents in Residential Care Homes for Persons with Disabilities

(RCHD should formulate the individual care plan (ICP) within 1 month after admission and conduct the first review in 6 months. RCHD 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/ eating behaviour	☐Nil ☐Yes If yes: ☐Soft meal ☐Minced ☐Pureed ☐Use of thickeners ☐Using feeding tubes: *nasogastric tube/ Percutaneous Endoscopic Gastrostomy feeding tubes ☐Fast eating behaviour ☐Binge eating	☐Referral to medical practitioner/ dietitian for follow-up is recommended ☐Referral to medical practitioner/ dietitian has been made ☐Others:_____
Falls	Number of fall within the past 6 months ☐Nil ☐Yes:_____times	☐Limb strength assessment/training is recommended ☐Balance assessment/training is recommended ☐Others:_____
Wandering	Number of wandering/missing within the past 6 months ☐Nil ☐Yes:_____times	☐Carry out anti-wandering measures/measures to prevent missing ☐Others:_____
Cognitive impairment	☐Nil ☐Yes (diagnosed by medical practitioner) If yes: ☐Mild ☐Moderate ☐Severe	☐Referral to medical practitioner for follow-up is recommended ☐Referral to medical practitioner has been made ☐Others:_____
Emotion appearance	Overall emotion appearance within the past 3 months: ☐Peaceful ☐Depressed ☐Manic ☐Anxious ☐Panic ☐Paranoid ☐Others:_____	☐Similar appearance as before ☐Different appearance from before →☐No follow-up is required →☐Referral to professional for intervention →☐Others:_____
Behavioural problems	☐Nil ☐Yes If yes, please specify:_____	☐Referral to medical practitioner/ clinical psychologist for follow-up/ treatment is recommended ☐Referral to medical practitioner/ clinical psychologist has been made ☐Others:_____

Item	Content	Remarks (if applicable)
Allergies	☐Nil ☐Yes If yes: ☐Food ☐Drugs ☐Others_____	☐Referral to medical practitioner for follow-up is recommended ☐Referral to medical practitioner 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 from 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)

Part IV: Assessment on the Need of Personal Care

Item	Content	Remarks (if applicable)
1. Nursing Care/Rehabilitation Need		
Nursing care/ Rehabilitation need	☐Nil ☐Yes If yes, please specify ☐Incontinence ☐No ☐Yes ☐Wound ☐No ☐Yes (location:) ☐Pressure injuries (pressure sores) ☐No ☐Yes (location:) ☐Use of catheters ☐No ☐Yes ☐Use of feeding tube ☐No ☐Yes ☐Peritoneal dialysis ☐No ☐Yes ☐Oral ☐No ☐Yes ☐Enhance limb strength ☐No ☐Yes ☐Others: _____	☐Referral to medical practitioner for follow-up is recommended ☐Referral to medical practitioner has been made ☐Others:_____
2. Social Care		
Interests/ hobbies	☐Travelling ☐Music ☐Drawing/Calligraphy/Art ☐Reading ☐Mahjong playing ☐TV/movies ☐Gardening ☐Doing handcrafts ☐Mass activities/games ☐Others:	☐Develop one's hobbies is recommended ☐Enhance one's hobbies is recommended ☐Others:_____

Item	Content	Remarks (if applicable)
Support network	☐Without relative(s) and/or friend(s) ☐With relative(s) and/or friend(s) If having relative(s) and/or friend(s), please specify: visit by relative(s) and/or friend(s) ☐Nil ☐Yes (no. of visit per month:___) outing with relative(s) and/or friend(s)/home leave ☐Nil ☐Yes (no. of outing/home leave per month:___)	☐Assist in building up a support network is recommended ☐Strengthen the support network is recommended ☐Others:_____
Social participation	☐Actively participating in activities and/or talking to others ☐Passively or occasionally participating in activities and/or talking to others ☐Refuse to participate in activities and/or talk to others ☐Unable to participate in activities and/or talk to others	☐Increase the chance of social participation is recommended ☐Encourage the resident to participate in social activities is recommended ☐Encourage the resident to assist in organising social activities is recommended ☐Others:_____
Day Training/ Vocational Training Services	☐Sheltered workshop ☐ICCMW ☐DAC ☐IVRSC ☐Supported employment ☐District Support Centre ☐Nil ☐Others:	☐Arrange day training/ vocational training services ☐Others
Others		

Part V: Other Professional Comment (e.g. social worker(s), occupational therapist(s), physiotherapist(s), speech therapist(s), etc.)

1.	Category of Profession: _____ Comment: _____
2.	Category of Profession: _____ Comment: _____
3.	Category of Profession: _____ Comment: _____
4.	Category of Profession: _____ Comment: _____

Part VI: Case Conference

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

Part VII: Care Plan/Regular Review

1. Complete this part upon formulation of the care plan (Date: / /)(dd/mm/yyyy)	
Care/ rehabilitation need of the resident	1. Item _____ of Part _____ 2. Item _____ of Part _____ 3. Item _____ of Part _____ 4. Item _____ of Part _____
Goals/ expected outcome	Item _____ ☐Refer to/Arrange for/Increase/Enhance _____ Item _____ ☐Refer to/Arrange for/Increase/Enhance _____ Item _____ ☐Refer to/Arrange for/Increase/Enhance _____ ☐Others: _____
Service plan/ strategies	Item _____ Implementation method _____ Item _____ Implementation method _____ Item _____ Implementation method _____
Date of review	/ / / (dd/mm/yyyy)

2. **Complete this part upon reviewing of the care plan**	
Date of review	/ / / (dd/mm/yyyy)
Respective staff	Name: Rank:
Outcome	Item ______ ☐Meet the goal, details/reasons ______ ☐Partially meet the goal, details/reasons ______ ☐Fail to meet the goal, details/reasons ______ ☐Others ______ Item ______ ☐Meet the goal, details/reasons ______ ☐Partially meet the goal, details/reasons ______ ☐Fail to meet the goal, details/reasons ______ ☐Others ______ Item ______ ☐Meet the goal, details/reasons ______ ☐Partially meet the goal, details/reasons ______ ☐Fail to meet the goal, details/reasons ______ ☐Others ______ Item ______ ☐Meet the goal, details/reasons ______ ☐Partially meet the goal, details/reasons ______ ☐Fail to meet the goal, details/reasons ______ ☐Others ______
Date of next review	/ / / (dd/mm/yyyy)
Comment of resident/ family member(s)	☐Agree to the outcome of review ☐Other comments:

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