Our Promise to You

You should have your assessments and care plans commenced within 24 hours and initial draft completed within 48 hours. Example of assessments include Falls Risk, Nutritional assessments, Wound assessment/Skin integrity.

The nurse will complete your care plans during the first few days of your stay.

Your care plan documentation should include plans related to but not exclusive to:

- Breathing & Circulation
- Communication
- Nutrition & Mealtimes
- Expressing Sexuality
- Personal Hygiene
- Controlling body temperature
- Recreation & Activities
- Sleep & Rest
- Safe Environment
- Elimination of Urine and Bowel
- Mobility & Falls Prevention
- Spiritual & End of life Care

Your care plans will be updated if there are any changes to your health and at a minimum every four months.

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A Guide to Planning your Care in CareChoice

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CareChoice

What is a Care Plan?

At CareChoice we strongly believe in the benefits of our residents choosing what is an enjoyable day for them. Planning your care is an essential component to your wellbeing and a successful happy stay in CareChoice. Active living, based on your interests and ability, is promoted in each home and referenced in your care plan.

Your care plan will include any identified agreed actions between you and your nurse to ensure that the nursing home team understand your choices, requests and nursing needs each day.

Your care plan will provide clear direction to all the staff with reference to your likes and dislikes and any health condition you may have. Developing your care plan assists in reducing any fear you or your family may have of the unknown.

Your care plan is based on the nursing process. There are five steps involved:

1. Assessment
2. Diagnosis
3. Planning
4. Implementing
5. Evaluating

Why is Planning Your Care Important?

During your first day in CareChoice, you will be assigned a nurse and health care assistant. The nurse will meet with you to complete nursing assessments. The answers to these assessments provide the nurse with the clinical information needed to start your plan of care within 48 hours of your admission to CareChoice.

The nurse in consultation with you and your medical notes will write a care plan for you using the five steps in the nursing process. The finished care plan will carefully balance your rights as a resident in CareChoice, your safety, and your health and wellbeing.

The nurse as a professional is accountable to ensure that your care plan is person centred, outlines your wishes and provide the clinical information required for the team in the nursing home to provide you with the best care possible.

The aim of your care plan is to provide reassurance to you and your family of the standard of care provided in CareChoice. Most importantly it is a communication tool used between the multidisciplinary team daily and it is updated with any changing needs you may have.

What is a Care Plan Meeting?

This meeting takes place with you and your nurse to agree a plan for your care.

- It is an opportunity for you, and a family member if you wish them to be present to ask any questions that you might have.
- Members of your care team may also be present.
- It is a time to discuss any care choices available to you to meet your future health needs.
- The nurse will print your care plans, read through them with you and discuss any questions you may have.
- It is important that you let the nurse know if you are happy with the details in your care plan.

The most important person at the meeting is you, the resident.