LIFE WITHOUT BARRIERS

NDIS LWB 5531 Personal Care Plan

Name:			
CIRTS ID:			
Address:			
Date of Plan:		**Review Due:**	

Part A

Important Personal Care Supports		
High-Intensity Daily Personal Activities (HIDPA)	☐ Yes	☐ N/A
Dysphagia Support	☐ Yes	☐ N/A
Behaviour Support	☐ Yes	☐ N/A
Transferring, Repositioning and Mobility (TRAM)	☐ Yes	☐ N/A

Preference Requirements: Describe your preferences for the Disability Support Worker/s (DSWs) who will support you with your personal care requirements, including gender, age, attributes and cultural needs.

Personal Care includes Showering/bathing, toileting, bowel and/or bladder care, menstrual care, oral health, dressing/undressing and personal grooming.

Include details on any flexibility regarding these preferences *(e.g. "My age preference is 40+; however, younger is ok if need be, as long as they are not in their 20s").*

There may be times when LWB is unable to meet your needs and preferences due to staff absentees/illness, workforce shortages or unforeseeable circumstances. When this occurs, the Disability Support Leader (DSL) or on-call during after hours, will contact you to discuss alternate options.

Gender Preference:	**Age of worker:** 20-29 ☐ 30-39 ☐ 40+☐	**No Preferences?** ☐

Additional comments:

- Share information collected in Part A with the team responsible for rostering your service, so that the Preferred Workers List can be updated.
- Record that this information was shared with the rostering team in a Progress Note on CIRTS

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Part B

	• For information on how to complete this Plan, see the NDIS LWB 5530 Personal Care Planning – Procedure • For guidance and information about providing Personal Care, see the NDIS LWB 5533 Delivering Personal Care – Procedure • Upload the completed Personal Care Plan as an attachment in the client's CIRTS record as follows: CIRTS Profile > Support > Personal Care > Add New Personal Care Record > Other Personal Care > [Enter fields of New Personal Care Record then select Add New Attachment] > Personal Care Plan • The Personal Care Plan must be reviewed at least annually or more often if the individual's support needs or circumstances change.

Self-Direction Only: The person can self-direct staff to support them as required and has chosen to not complete Part B	Yes ☐ ➡ No further action needed

Section 1: General support information	
What is important <u>to</u> me - General preferences and needs regarding my overall personal care support: *(e.g. cultural preferences, personal boundaries, sensory needs and/or communication supports specific to my personal care support)*	
What is important <u>for</u> me - Associated Support Plans that relate to my personal care support: *(e.g. TRAM Plan, Allergy Response Plan, Behaviour Support Plan, Epilepsy Management Plan, Oral Health Plan, HIDPA Protocols etc)*	

NDIS LWB 5531 Personal Care Plan

Section 2: Personal Care Support Required			
Dressing / Undressing	**Assistance Required?** Yes ☐ No ☐		
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐		
What is important <u>to</u> me about this task? *(e.g. I choose my outfits, I dress my upper body myself, you offer me two options that I can choose from)*			
What is important <u>for</u> me about this task? *(I need assistance dressing my lower body, you straighten out my clothes so I am not sitting on creases to ensure skin integrity)*			
Bathing/Showering	**Assistance Required?** Yes ☐ No ☐		
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐		
How often I do this task, and what time I like to do it:		**How long this task usually takes:**	
What is important <u>to</u> me about this task? *(e.g. I like to listen to music in the shower, I hold the shower hose, you let me smell the body wash as I like the smell of it etc)*			
What is important <u>for</u> me about this task? *(e.g. I have a shower in the morning and evening, I need you to lift up my skin folds and wash and dry these areas thoroughly, my hair is washed every second day, use my ceiling hoist to transfer me onto the shower commode)*			

Personal Grooming (shaving, styling hair, make-up, jewellery)	**Assistance Required?** Yes ☐ No ☐	
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐	
What is important <u>to</u> me about this task? *(e.g. I brush my own hair but need help putting it in a ponytail, that the same brands of toiletries are used each time, I get to choose how I would like my hair styled each morning)*		
What is important <u>for</u> me about this task? *(e.g. you brush my hair at least twice a day to stop it from getting knotty, you use sensitive shaving cream to stop me from getting a rash, my face is shaved every Sunday morning before my shower etc)*		
Oral Hygiene	**Assistance Required?** Yes ☐ No ☐	
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐	
What is important <u>to</u> me about this task? *(e.g. you use only peppermint flavoured toothpaste, you let me spit out the toothpaste regularly as I don't like too many bubbles in my mouth)*		
What is important <u>for</u> me about this task? *(e.g. you brush my teeth morning and night following the directions in my oral health care plan, I use an electric toothbrush)*		

Bowel/Bladder Care (Toileting and/or changing continence aids)	**Assistance Required?** Yes ☐ No ☐
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐
What is important <u>to</u> me about this task? *(e.g. you don't talk about my incontinence in front of other people, you close my blinds and bedroom door when changing my continence items etc)*	
What is important <u>for</u> me about this task? *(e.g. frequency of continence aid changes is no more than 3 hours apart, you use my preferred aids, I get hoisted onto my bed with 2 staff for all changes, I am physically assisted to sit on my toilet commode, I need you to walk next to me while I use my walker and remind me to go slow, as I am at a high risk of falls)*	
Menstrual Care	**Assistance Required?** Yes ☐ No ☐
Type of assistance I need:	☐ Verbal / physical prompt ☐ Hand on hand ☐ Physical Assistance Support Ratio: 1:1 ☐ 2:1 ☐
What is important <u>to</u> me about this task? *(e.g. you don't talk about this support in front of my housemates)*	
What is important <u>for</u> me about this task? *(e.g. timing/frequency of sanitary items, personal hygiene is maintained etc)*	

Section 3: Staff Acknowledgment			
By signing below, I confirm that: ✓ I developed this Personal Care Plan in consultation with **insert name** and, if relevant, their authorised decision maker **insert name** ✓ I have fully explained the details of this plan and how it will be implemented, to **insert name** and their authorised decision maker ✓ **insert name** has been provided with a copy of this plan, and they have provided verbal consent to its implementation			
Name of LWB Representative:		**Signature:**	
Date verbal consent received:		**LWB Representative has recorded a progress note of the conversation on CIRTS:**	Yes ☐ No ☐

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Section 4: LWB Staff Declaration (All Disability Support Workers who work with this person to sign)

By signing below, I confirm that:

- ✓ I have read and understand this Personal Care Plan
- ✓ I understand my responsibility in supporting the individual with their personal care requirements and preferences.
- ✓ I have received instruction/training in Personal Care requirements and understand how to use any equipment/aids

Name		**Sign**		**Date**		**Name**		**Sign**		**Date**	
Name		**Sign**		**Date**		**Name**		**Sign**		**Date**	
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