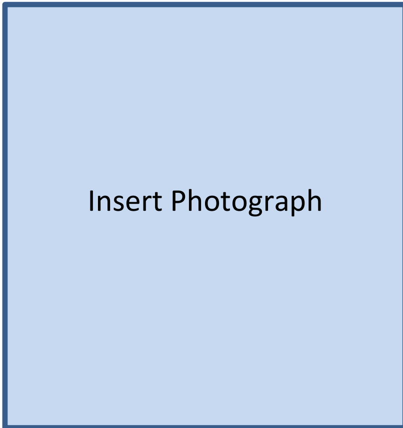
Respite Services



My All About Me Assessment

The All About Me Assessment is completed to identify my care and support needs, and to help all people working with me to get to know me!

The All About Me Assessment should be completed with:

- The Respite User (where possible)
- The Parents/Representatives
- A Residential staff member / Keyworker (annually)

This All About Me Assessment is reviewed annually.

Date of completion: ___________________________ Next Review date*: ____________________

Signed upon completion by participants:

- Respite User (where possible) Name:_______________________________________

  Signed: ____ Date: _____________

- Parent/Representative:____

  Signed: ____ Date: ______________

- Keyworker Name: ____

  Signed: ____ Date: ______________

***Note that a record of review dates is kept in the Person Centred Plan**

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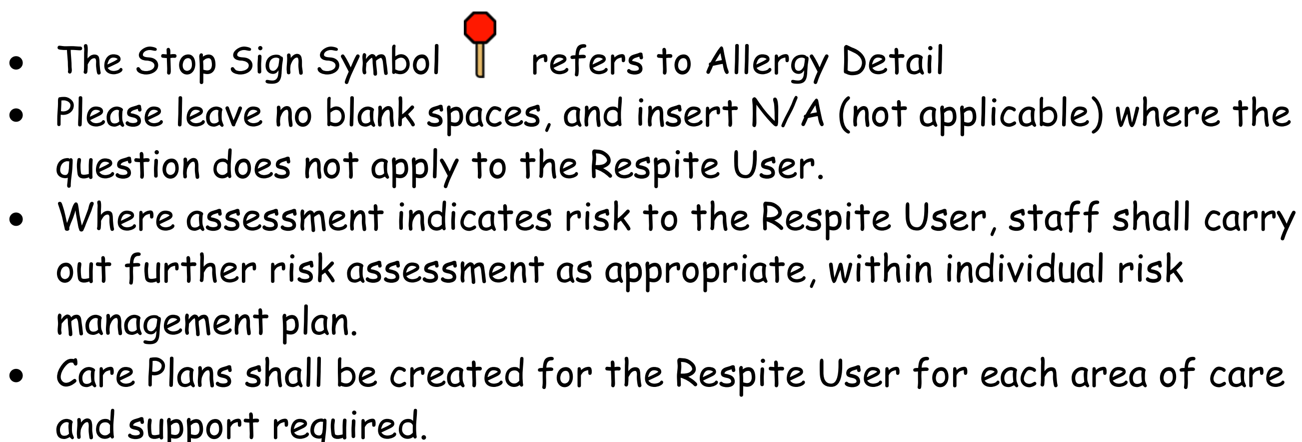
Notes:



- The Stop Sign Symbol refers to Allergy Detail
- Please leave no blank spaces, and insert N/A (not applicable) where the question does not apply to the Respite User.
- Where assessment indicates risk to the Respite User, staff shall carry out further risk assessment as appropriate, within individual risk management plan.
- Care Plans shall be created for the Respite User for each area of care and support required.

My Details

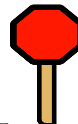
1.0 About Me

My name is ______________________________________.

I am ___________________________ years old.

My birthday is (date-month-year) _________________________

I live in: ____



I am allergic to: ______________________ My Epipen is located___________________

My hair colour is: ______________________ My eye colour is________________________

Name of Lead Intellectual Disability Service:

____

Name of Other Respite Services availed of, if applicable _____________________________

2.0 My Important Contact Details

Parent/Representative Contact Details (1):	Name:___________________________________ Address:________________________________ ____ Phone:__________________________________ Relationship to Respite User: _____________
Parent/Representative Contact Details (2):	Name:___________________________________ Address:________________________________ _______________________________________ Phone:_________________________________ Relationship to Respite User: ____________

If both parents /representative are away next point of contact Contact Details (3):	Name:______________________________________ Address:____________________________________ ____ Phone:_____________________________________ Relationship to Respite User: ____________

Are both Parents/Representatives to be contacted? Y[ ] N[ ]

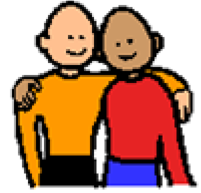
Please provide details regarding contact if applicable: ____________________________________

____

____

____

GP Details: Name:_______________________________ Address:_____________________________ ___________________________________ Phone:______________________________	Consultant Details: Name:_______________________________ Address:_____________________________ _____________________________________ Phone:_________________________________



3.0 My Family Details

My Mum's name is ____________________________.

I call her _______________________________________ (e.g. mama/ sign mum).

My Dad's name is ______________________________.

I call him _______________________________________ (e.g. dada/ sign dad).

I have ____________ sisters and ______________ brothers.

Their names are ____.

I call them / I sign (Lámh) ____.

My relatives and people who are important to me are

____

____.

4.0 My Daily Routine

I go to ____school/Day service.

My morning routine is ____

____.

After school/Day Placement, my evening routine is

____

____.

At weekends, my daily routine is ____

____.

5.0 My Preferred interests/activities:

____

____

____

____

____

____

____

____

____

6.0 Do I need support with my bedtime routine?

I usually go to bed at ____________.

At weekends, I go to bed at ______________________.

I wear ____to bed.

I sleep ____.

____

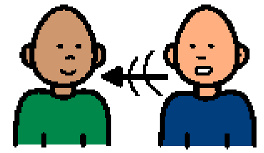
____

(E.g. with sides on my bed, sometimes I sit up sleeping)

#for Keyworker:

Is Bedtime Routine care plan in place? Y ( ) ***N*** ( ) ***Date______***

My Support Needs Assessments



7.0 How I Communicate

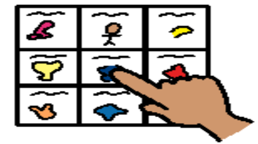
My language/Communication: (e.g. I use words, Lámh signs, facial expressions, gestures, sounds, mixture of these, uses repetition, echoes words and/or phrases)________________________

____
____
____
____

Other things you need to know to help me with my communication, ________________________

____

____
____
____



My Sensory Assessment

My Sensory Experience (e.g. I pull away when touched, strongly avoid certain smells, foods, clothes, exhibits unusual or non-response to pain, heat or cold):

____

____

Social Interaction (e.g. enjoy spend time on my own, less responsive to social cues such as eye contact or smiles)

____
____

#For Key Worker: Has Communication Passport / Communication Support Plan been completed based on Communication and Sensory Assessments? Yes [ ] No [ ] Date__________

9.0 My Behaviour Assessment

Positive Behaviour Support: I ______________ (have / do not have) a Positive Behaviour Support Plan.

This was completed ______________ (include date) and is reviewed ____________________.

My Phobias/Fears: ____.

____

Wandering/Absence without required supervision (e.g. I have a history of wandering from house/outings, running away from carers in public settings).

____

____

I have received a psychological assessment: Yes [ ] No [ ]

Has copy of assessment been provided? Yes [ ] No [ ]

#For Keyworker: Has Behaviour Support Plan/Protocol, if applicable, been added to PCP:

Y [ ] N [ ]   Date: ___________________

10.0 Food, Eating and Drinking Assessment

Food Allergies (if applicable):_______________________

Dietary requirement from a Health Care Professional*: (e.g. GP, Dietician, Speech and Language Therapist, Consultant). Please tick Yes or No and Provide Details: ** For any dietary requirement from a Health Care Professional [HCP], details of the assessment/instruction by the HCP must be provided to Staff. This will form the base for an Eating and Drinking Care Plan for the Respite User.*

- Modified Consistency Diet (e.g. soft, minced moist, pureed, liquidised): Yes [ ] No [ ]
  Details:____

- Diabetic Diet: Yes [ ] No [ ] *Details* ____
- Gluten Free (Coeliac) diet: Yes [ ] No [ ] *Details*: ______________________________
- High Protein High Calorie Diet: Yes [ ] No [ ] *Details*: ____________________________
- PEG/other Enteral Feeding: Yes [ ] No [ ] *Details*: _____________________________
- Other diet from a Health Care Profession: Yes [ ] No [ ] *Details*:

  ____

Dietary requests from parent/guardian*:* ____

My Likes and Dislikes

I like to eat and drink: ____

____

____.

I do NOT like to eat or drink:

____

____.

Please include foods for breakfast, lunch, snack and dinner times above.

I use ___________________________ when I am eating (e.g. type of spoon, fork, plate etc.).

I use ___________________________ when I am drinking. (E.g. type of cup).

My Preferred* consistency of my food is (e.g. no lumps, cut up very small, etc.)____ ** Note medical modified consistency diets are listed above.*

The supports I need when I am eating____

____

____

(e.g. full assistance, hand over hand, independent).

Are recommendations/guidelines from a Health Care Professional attached? (If applicable):
Yes [ ] No [ ]

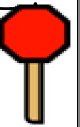
Other things that you need to know to help with my eating and drinking ____________________
____.

#For Key Worker: Has Eating and Drinking Care Plan been completed and in PCP? Y [ ] N [ ]
Date: _________

11.0 My Health and Nursing Supports Assessment

My Health History (Medical History):
____
____
____

My medication/non-food allergy details: ____



Vacination Record

BCG	Yes ☐ No ☐	Date:	____________
MMR	Yes ☐ No ☐	Date:	____________
Polio	Yes ☐ No ☐	Date:	____________
Diphtheria	Yes ☐ No ☐	Date:	____________
Hep B	Yes ☐ No ☐	Date:	____________
Pneumonia	Yes ☐ No ☐	Date:	____________
Tetanus	Yes ☐ No ☐	Date:	____________
H1N1 (Swine Flu)	Yes ☐ No ☐	Date:	____________
Flu Vaccine, Seasonal	Yes ☐ No ☐	Date:	____________

Other: --

My Current Health Needs: ____

____

My medical conditions INCLUDE the following (tick Yes or No): (If yes, please detail requirements):

Epilepsy: Yes[ ] No[ ] Details:________________________________

- *If yes: Epilepsy Medication? Yes [ ] No[ ]*
- *Type of Epilespy Medication ____*
- *If Midazolam, is Midazolam criteria provided with Kardex: Yes[ ] No[ ]*

Diabetes: Yes [ ] No [ ] Details:__________________________________

Asthma: Yes [ ] No [ ] Details:__________________________________

Heart Condition: Yes [ ] No [ ] Details:__________________________________

Incontinence*: Yes [ ] No [ ] Details:__________________________________

**If Yes, are family/representative to provide spare clothing for the Respite User? Yes [ ] No [ ]*

Other conditions:____

Any further details for the above Medical Conditions relevant to my Respite Stay:______________

____

My Hearing, Eyesight and Dental Health

My current Hearing is: ____.

(I wear a hearing aid: Yes [ ] No [ ]

My current Vision is: ____.

(I wear Glasses: Yes [ ] No [ ]

My current Dental Health is: ____.

(I use dental supports/retainer etc.: Yes[ ] No[ ]

My Pain Management

I _______________ (do/do not) experience Pain on a regular basis in relation to my health.

Pain Management details if yes:

____

____

I have been prescribed medication for pain management (See Medication Administration Record: Yes [ ] No [ ]

My Medications

I do not take prescribed medication (tick) Yes [ ] No [ ]

I take prescribed medication (See Medication Administration Record: Yes [ ] No [ ]

____

Could I be considered for Self-Medicating? Yes [ ] No [ ]

My Weight Management

Weight (Kg): ___________________

Further detail from parents/representative or health care professional regarding weight/nutritional status and height (describe or mark N/A):

____

____

I am on medication which may be impacted by a change in my weight? Yes [ ] No [ ]

I require support with weight management Yes [ ] No [ ]

____

____

Health Care Professionals involved in My Support:

Specialist: Yes ( ) No ( )

Name & Profession: ______________________________ Telephone No:

Address:

Social Worker: Yes ( ) No ( )

Name: ____ Telephone No:

Address:

Physiotherapist: Yes ( ) No ( )

Name: ____ Telephone No:

Address:

Speech and Language Therapist: Yes ( ) No ( )

Name: ____ Telephone No:

Address:

Psychologist: Yes ( ) No ( )

Name: ____ Telephone No:

Address:

Dietitian: Yes ( ) No ( )

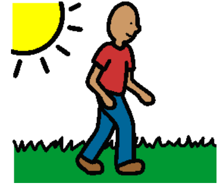
Name: ____ Telephone No:

Address:

Other: How often:

Name: Telephone No:

12.0 My Mobility Assessment



I am ____.

(E.g. mobile/independent, wheelchair user, requires support to mobilise, can weight bear)

Wheelchair details if applicable: ____.

Other Equipment details if applicable: ______________________________________.

I need assistance ____.

(Using stairs, moving from different surfaces, stepping down, transferring in and out of wheelchair)

I am able to get in and out of a bath and shower without assistance. Yes [ ] No [ ]

**I require the assistant of one person to get in/out of the bath and shower Yes [ ] No [ ]*

**I require full support to get in and out of a bath and shower Yes [ ] No [ ]*

Please note any specialised Equipment I will require for my stay: ______________________

____Guidelines attached? Yes [ ] No [ ]

I have a history of falls/falling Yes [ ] No [ ]

Details: ____

#for Keyworker:

Has manual handling assessment been completed? Yes [ ] No [ ] Date: _______

Where indicated by poor mobility/falls history, falls risk assessment been completed?

Yes [ ] No [ ] Date: _________

Has Mobility Support Plan been put in place where appropriate? Yes [ ] No [ ]

Date: _________

13.0 My Skin Assessment

I have a skin condition yes [ ] No [ ]

Please provide details if applicable: ____

I have a wound/skin pressure ulcer: Yes [ ] No [ ]

Details if applicable: ____

#For Keyworker: Where indicated, has further risk assessment and care plan been completed? Yes [ ] No [ ] Date: ________

14.0 My Personal Care and Dressing Assessment

(Personal care includes showering, bathing, washing hands, washing face, washing teeth, brushing hair, incontinence care, menstruation, dressing, shaving etc.)

The supports I need to help with my personal care________________________________.

(E.g. independent, prompting, full assistance)

When helping me with my personal care, it is good to know ___________________________

____.

(E.g. I don't like water on my head)

When using the bathroom/being changed, I would like you to __________________________

____.

(E.g. follow my routine, show me what is happening, give me my privacy)

The supports I need to help with my dressing ____________________________________.

When helping me with my dressing, it is good to know ______________________________

____.

(E.g. I will hold up my hand to help, I need you to open out my socks)

Please note any additional care that is needed including menstruation ____________________

____.

My dental care:

I use ____________________________ when brushing my teeth.

When brushing my teeth, it works best to ________________________________

____.

***#For Key Worker: Has Intimate Care Plan been completed? Yes* [ ] *No* [ ]**
***Date:* _________**

15.0 My Physical/Mechanical Safety Supports Assessment

I use the following supports at home (for wheelchair, protection from injury at night, mood, sleeping, preventing access to body etc.):

- Lap Belts: ▯
- Chest harness: ▯
- All in One Vest ▯
- All in One Vest with Leggings ▯
- Cocoon Bed ▯
- Bed Rails/Cot sides: ▯

Other (Insert details):

____

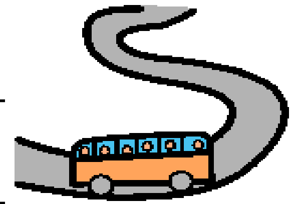
#For Keyworker: Where indicated, has appropriate assessment, care plan (including criteria for use to ensure least restrictive and for shortest time), and consent been completed?
***Yes* [ ] *No* [ ] *Date:* _________**

16.0 My Money Supports

The supports I require with my money:

(E.g. I need assistance with my money)

17.0 My Travel Supports



When travelling in car, I ____

(E.g. booster seat, seat me behind passenger seat).

When travelling on a bus, I ______________________________________

(E.g. booster seat, wheelchair clamp).

When travelling, it works best to ____.

(E.g. play some music, look out the window, have a toy).

Please include any other information that is relevant for my stay at respite!

! PLEASE NOTE:

AN UP TO DATE KARDEX MUST BE COMPLETED BY THE GP AND KEPT ON FILE FOR ADMINSITRATION OF MEDICATIONS AS PER SJOGCS POLICY

#For Key Worker: Where indicated in above assessment has the following plan/s been put in place for the Respite User:

Medication Management Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Epilepsy Management Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Diabetes Management Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Dental Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Circulation Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Chiropody Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Breathing Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Vision Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Hearing Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Intimate Health Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Elimination Care Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Pain Management Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Weight Management Plan: Yes ☐ No ☐ Signed: ______________________ Date______________

Self-medicating Assessment Yes ☐ No ☐ Signed: ______________________ Date______________

Other Health & Nursing Management Plans (please list): ____

____

____

____

Thank you

Family/Representative Input: Approval of All About Me Assessment

I am satisfied that I have provided all relevant information to Respite Staff and have not left out any important information which may impact their ability to provide care and support to the Respite User

Name (Print): ___________________________

Signature: ___________________________

Date: ___________________________

Management Input: Approval of All About Me Assessment

I am satisfied that:

- The above assessment has been completed appropriately
- All required information has been gathered

Please insert comment, as appropriate:

Keyworker (Print Name): ________________________________

Signature: ________________________________

Date: ________________________________

Person in Charge (Print name): ________________________________

Signature: ________________________________

Date: ________________________________