

Your Support Plan. Helping Us To Help You.



Supported Accommodation at East North East Homes
Leads for **LIFE.** Living
Independently in a
Friendly
Environment

YOUR SUPPORT PLAN
“Promoting Independent
living and choice”

Tenant: _____

Scheme: _____

Warden: _____



“YOUR SUPPORT PLAN” “HELPING US TO HELP YOU”.

❖ **This is a confidential document.**

This means that the only people who have access to this information are you and staff on a need to know basis. If you would like access to this information please contact your warden. We will only share information with other agencies where you agree that we can. This document is **not** part of a financial benefits review and does **not** affect any benefits you receive.

You have the right to discuss matters with staff in confidence and the right to be treated fairly, equally and in the knowledge that your cultural beliefs will be respected.

This document is kept according to the data protection act in a secure environment.

If you would also like to hold a copy of this document please ask your warden who will be glad to get a copy for you.

❖ **Why do You need a support plan?**

This will help us to identify any risks or things you may need assistance with, it will also help us to provide you with the most appropriate support to help you stay independent and maintain your health and well-being.

Supporting people expects its providers to record and monitor the services they provide to their tenants and to demonstrate that they are specific to your individual needs and wishes. This document will assist in ensuring that we are meeting what is expected of us.

❖ **If your circumstances change.**

We will review your support plans approximately every 6 months, however if you would like to discuss this sooner please ask your warden. Also any major changes in your circumstances or health will prompt an earlier review. Any reviews will be arranged at a time convenient to you where we can. If you have any comments that may improve our support plan and the process, your views and opinions are greatly appreciated.

❖ **Working with families and other agencies.**

When needed we'll liaise with other professionals and your families on your behalf to ensure that your health and needs are being catered for. We respect your wishes and ensure that we work to them.

PERSONAL INFORMATION

NAME:		DATE OF BIRTH:	AGE:
PREFERRED NAME:		RELIGION:	
ADDRESS		ETHNIC ORIGIN:	
TEL NO:	MOBILE:	TRANSLATION OR LANGUAGE NEEDS:	
NEXT OF KIN: YES <input type="checkbox"/> NO <input type="checkbox"/>		KEYHOLDER: YES <input type="checkbox"/> NO <input type="checkbox"/>	
GP NAME:		GP NAME:	
NAME:		SURGERY:	
ADDRESS:		ADDRESS:	
TEL NO:		TEL NO:	
RELATIONSHIP:		KNOWN MEDICAL CONDITIONS:	ESSENTIAL MEDICATION: YES <input type="checkbox"/> NO <input type="checkbox"/>
OTHER CONTACT - RELATIONSHIP:			
NAME:			
ADDRESS:			
TEL NO:	KEY HOLDER YES <input type="checkbox"/> NO <input type="checkbox"/>	ALLERGIES:	
		ABLE TO SELF MEDICATE: YES <input type="checkbox"/> NO <input type="checkbox"/>	
OXYGEN STORED AT HOME:		ASSISTANCE PROVIDED BY:	

1	Living in the Scheme	Yes	No	N/A	Comments
a)	Security and door entry system				
	Are you able to operate the door entry system?				
	Are you able to lock and unlock your front door?				
b)	Emergency call Alarm				
	Are you able to operate the Care Ring call system?				
c)	Use of laundry facilities				
	Are you able to use the laundry facilities independently?				
d)	Reporting repairs				
	Are you able to report repairs?				
	Do you need help to report repairs?				
e)	Understanding ENEHL complaints procedure				
	Do you know how to make a formal complaint?				
f)	Any neighbour disputes / problems				
	Do you require any assistance to resolve any disputes / problems you may have with a neighbour or other resident in the scheme?				Referred to: Date:
	Do you need information on our ASB policy and team?				Outcome: Review:
g)	Fire safety and fire prevention				
	Are you aware of fire safety and fire prevention in your home?				
	Are you able to hear the fire alarm sounding?				
	Are you able to self test your smoke detector in your home?				
	Do you require assistance from the Fire Safety Service in making your home safer?				Referred to: Date:
					Outcome: Review:

2	Mobility	Yes	No	N/A	Comments
a)	Prone to falls. Falls risk assessment:				
	Can we liaise with the falls monitoring team on your behalf?				Referral to: Outcome: Date: Review:
b)	Independent / Housebound				
	Can you manage independently indoors?				
c)	Outside the home				
	Do you need / use equipment to remain mobile and independent outdoors?				Referral to: Outcome: Date: Review:
d)	Aids and adaptations				
	Do you currently use any aids or have you any adaptations fitted to assist you with mobility? Assessment required:				Referral to: Outcome: Date: Review:
e)	Transport needs				
	Do you require information or assistance with transportation eg to hospital, GP?				Referral to: Outcome: Date: Review:

3	Communications	Yes	No	N/A	Comments
a)	Use of English language				
	Do you need assistance to understand any letters / bills?				
	Do you need assistance making telephone calls?				
b)	Local Services and Information:				
	Do you require any information on local services and transport links?				
c)	Access to Welfare Benefits Advice				
	Do you require assistance with any of the following. <ul style="list-style-type: none"> • Benefits advice • Fuel poverty • Rent arrears • Debt counselling 				Referral/s made to: Date: Outcome: Review:
d)	Sensory / Visual Impairment				
	Do you consider yourself to have a sensory or visual impairment?				Referral to: Date: Outcome: Review:
e)	Advocacy Support				
	Do you need someone to give you advice and, if necessary, act on your behalf?				Referral to: Date: Outcome: Review:

4	Social Involvement / About You:	Yes	No	N/A	Comments
a)	Contact with other Tenants				
	Would you like introducing to or information on local community schemes / groups?				
b)	Support from family and friends				
	Do your friends and / or family visit regularly?				
c)	Attend social activities				
	Do you like to join in social activities arranged within the scheme?				
d)	Hobbies and Interests				
	Have you any skills or suggestions towards activities and groups?				
e)	Attend appointments				
	Are you able to attend appointments e.g. doctor's or hospital ?				
f)	Cultural needs				
	Do you require any information or assistance to ensure that your cultural needs are being met? Diet, dress, food, social support networks?				
g)	Religious needs				
	Do you have any specific religious needs or values which are currently not being met?				

h)	Do you Smoke				
	Would you like any information / support on stopping?				
i)	Policy given re smoking when staff are in your home?				YES <input type="checkbox"/> NO <input type="checkbox"/>

Your warden is unable to provide any of the following services personally. However we aim to assist you by making referrals to other agencies and can provide information on accessing the services if you require them.

5	Daily Living Skills	Independent	Assistance	Comments / Referrals
a)	Cooking			
	Are you able to prepare and cook a hot meal. If No would you like assistance accessing services?			
b)	Shopping			
	Can you do your own shopping?			
c)	Housework			
	Can you manage to do your own cleaning?			
d)	Laundry			
	Can you do your own washing / ironing?			
e)	Personal Care			
	Are you able to wash, bathe, dress and toilet yourself?			Referral: Date: Outcome: Review:

Please detail support and providers:

	YES	NO								
Meals services:			Provided by:	Please tick which days:						
				Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Personal Care / Home Support.			Provided by:							
Attend Day Centre			Address and Contact Details:	Please tick which days:						
				Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Other Support please give details.				Please tick which days:						
				Mon	Tues	Weds	Thurs	Fri	Sat	Sun

Useful support providers and local contact details:

Provider:	Office / Location	Telephone Numbers
Care / Support Workers		
Social Worker		
Community Psychiatric Nurse		
Local Housing Tenancy Support Officer:		
District Nurses		

Useful Support Providers and Contact Details:	

DO YOU CONSIDER YOURSELF TO BE VULNERABLE OR AT RISK FROM OTHERS? YES NO DON'T KNOW

Additional Information

Do you have issues with any of the following:	Yes	No	Additional Information:
Alcohol Dependency			
Substance Misuse			
Mental Health			
Other: Please specify			

YOUR SUPPORT PLAN AGREEMENT

Actions required, Agreed outcome	Time scales & ownership

Agreed date of review:

Any other comments:

I AGREE WITH THE CONTENTS OF THIS DOCUMENT AND UNDERSTAND IT MAY BE SHARED WITH STAFF INVOLVED WITH MY SUPPORT AND WELLBEING

Tenant's Signature:		Date:	
Warden's signature:		Date:	

DATE	RECORD (NOTES)	ACTION REQUIRED	Tenant's Signature	Warden's Signature

DATE	RECORD (NOTES)	ACTION REQUIRED	Tenant's Signature	Warden's Signature

REVIEW DATE	RECORD OF CHANGES (IF ANY)	REFERRAL REQUIRED	ACTION TAKEN	Tenant's Signature	Warden's Signature

REVIEW DATE	RECORD OF CHANGES (IF ANY)	REFERRAL REQUIRED	ACTION TAKEN	Tenant's Signature	Warden's Signature