



Care Plan Setup

1. General Guidance	3
2. Initial Patient Setup	4
3. Patient Information	4
3.1 Emergency Plans	5
4. Care Management	6
4.1 Care Goals	6
4.2. Team Members	6
4.3 Contact Information	8
4.4. Other information	8
5. Care Plan setup	10
5.1 General Observations	10
5.1.1 Temperature	10
5.1.2 Pain	10
5.1.3 Height and Weight	10
5.1.4 Vitals	11
4.2 Activities of Daily Living	12
4.2.1 Scheduled and PRN Medications	12
4.2.2 Nutrition	15
4.2.3 Toileting	19
4.2.4 Sleep	20
4.3 Wellbeing	20
4.3.1 Mood	20
4.3.2 Regular Activities	21
4.4 Neurological	22
4.4.1 Seizures	22
4.4.2 Movements	23
4.5 Gastroenterology	24
4.5.1 BSL & Ketones	24
4.6 Respiratory	25
4.6.1 O2 Therapy	25
4.6.2 Suctioning	26
4.6.3 Chest Physio	26
4.7 Allied Health	27
4.7.1 Equipment	27

4.8 Positive Behaviour Supports

29

4.8.1 Positive Behaviour Supports

28



1. General Guidance

Thank you for being part of the CareCorner community. Our platform is designed to make care coordination simpler, more connected, and truly centred around the person receiving care. As the Administrator, you play a key role in ensuring information is accurate, timely, and accessible to the whole team.

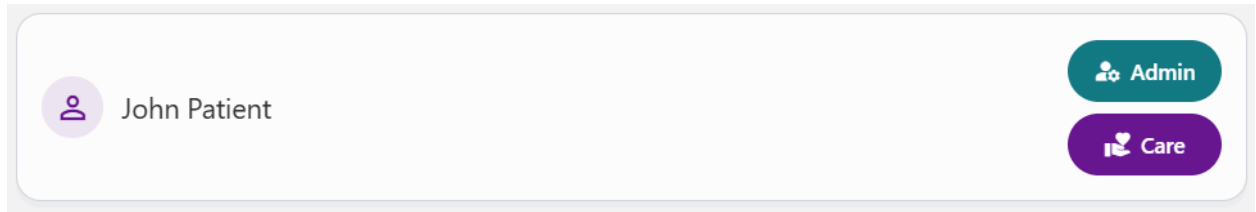
- We strongly **recommend completing this process on a desktop / laptop** or maybe a tablet as it is easier to also copy and paste from existing documents.
- When you initially sign up as a new user, you will have to verify your account via a link sent to your email address.
- You can setup multiple patients under your account and invite dedicated team members.
- Ensure that the “updated” command appears at the bottom of the screen when you make changes to the care plan.
- Always double check in the Care taker mode (e.g. in the Care Plan) that the changes have come through successfully and that the care plan is written in a way that works for the team and that there are no errors.
- You can make another person an “Admin” for your account. You are able to remove them as well. The person initially setting up can never be removed as the admin.



2. Initial Patient Setup

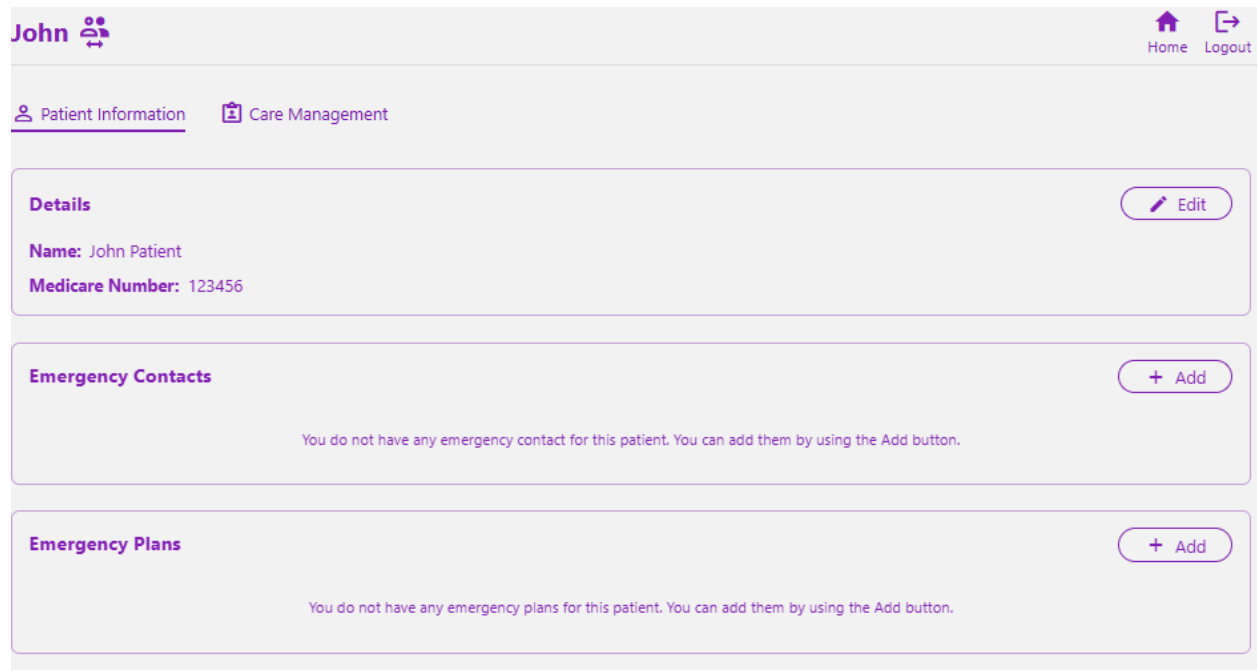
You will be asked some generic information about the patient you are setting up. This data can be edited at a later stage and the fields are not mandatory.

Editing information is always possible via the Admin button for each patient on your login screen.



3. Patient Information

The Patient information tab includes generic info about the person, their Emergency contacts and customised Emergency Plans.



3.1 Emergency Plans

The Admin can create as many Emergency plans as they wish and they can be labelled in customised ways.

Each Emergency Plan follows the same pattern:

- Title of the Plan
- Signs in the patient indicating to act on the Emergency Plan
- Actions to be taken
- Actions is symptoms persist
- When to contact an Emergency contact

[Patient Information](#) [Care Management](#)

[← Emergency Plans](#)

Plan

Select a plan or manually enter a name...

What are the signs to act on the Emergency Plan?

List the signs in detail...

What action(s) should be taken?

List the actions to be taken for the emergency...

What if the signs persist?

Please enter detailed handling instructions...

When do you want an Emergency contact to be called?

Please describe the conditions that warrant an emergency contact call...



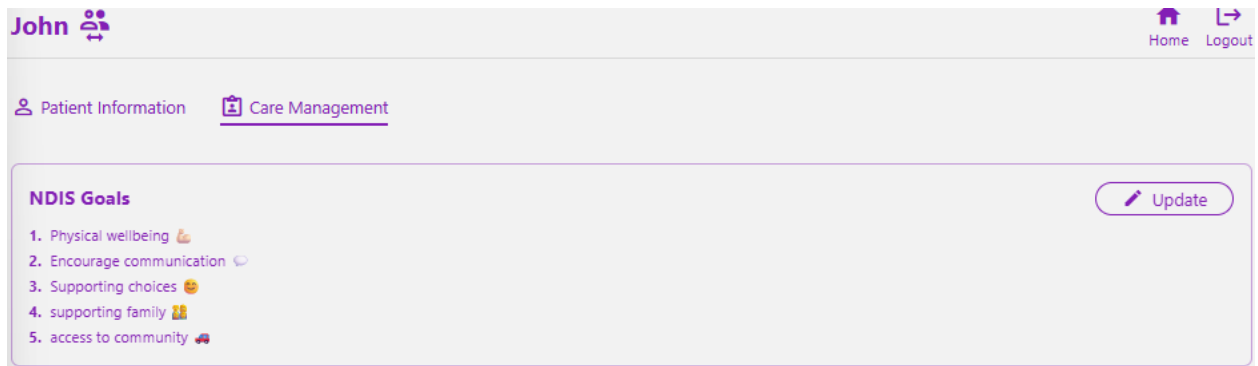
4. Care Management

4.1 Care Goals

This allows the admin to define the patient's Care goals. Those goals can be aligned with NDIS plans or as discussed with the wider Care team.

It is recommended to use short description for the Care Goals as they will appear in the Progress notes and act as reminders for the team to consider the Care Goals on every shift.

The Admin might choose to set one goal as "NONE" or "NA" to enable the care takers to select this option if they have not been able to work on any goals in the shift.

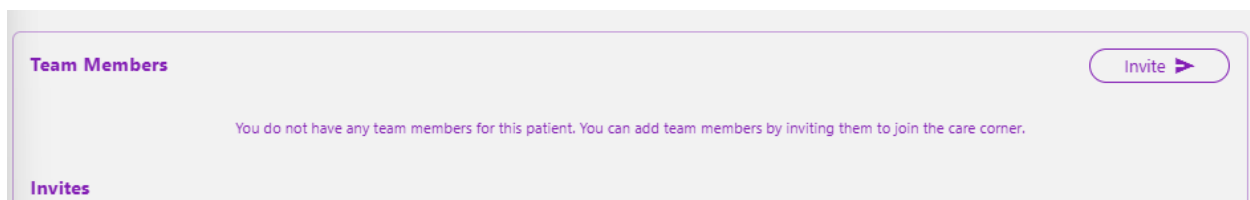


The screenshot shows a user interface for a patient named John. At the top right, there are links for 'Home' and 'Logout'. Below the patient name, there are two navigation tabs: 'Patient Information' and 'Care Management', with 'Care Management' being the active tab. The main content area is titled 'NDIS Goals' and contains a list of five goals: 1. Physical wellbeing, 2. Encourage communication, 3. Supporting choices, 4. supporting family, and 5. access to community. An 'Update' button is located in the top right corner of the goals list.

4.2. Team Members

The Admin invites the whole care team via entering their email addresses. Please be mindful that these email addresses are case sensitive.

Depending on the approach taken by the Admin, you might want to invite family members, Allied Health professionals, medical progressionals or anyone else involved in the Care of the care recipient.



The screenshot shows a user interface for 'Team Members'. At the top right, there is an 'Invite' button with a right-pointing arrow. Below the button, a message states: 'You do not have any team members for this patient. You can add team members by inviting them to join the care corner.' At the bottom left, there is a section header for 'Invites'.



Team members such as family members, allied health professionals, and medical professionals receive an invitation to CareCorner.

Care Corner - Invite Inbox x 🖨️ 📄

noreply@carecorner.net.au 14:34 (1 minute ago) ☆ 😊 ↶ ⋮

to me ▾

You've Been Invited!

Hello,

Maria has invited you to access patient information for Jane Doe on our platform. Join our secure platform to view and collaborate on care plans.

This invitation gives you access to:


- View patient information
- Access history and records
- Collaborate on care plans

Click the button below to accept the invitation and start collaborating on care plans.

[Accept Invitation](#)

This invitation expires in 7 days and you'll need an account to accept the invitation.

To access the patient's CareCorner profile, they click *Accept Invitation*, which takes them to the CareCorner login page. Team members then select *Don't have an account* and complete the details to view and access the patient they are caring for.



Welcome to Care Corner!

Email*

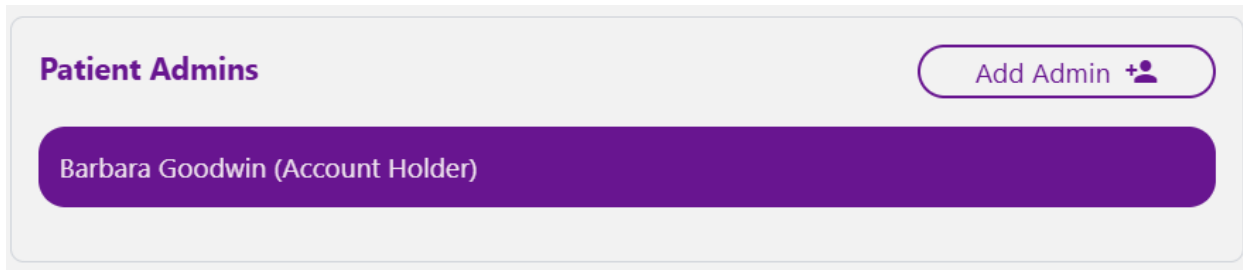
Password*

[Log In](#)

[Forgot Password?](#) [Don't have an account?](#)

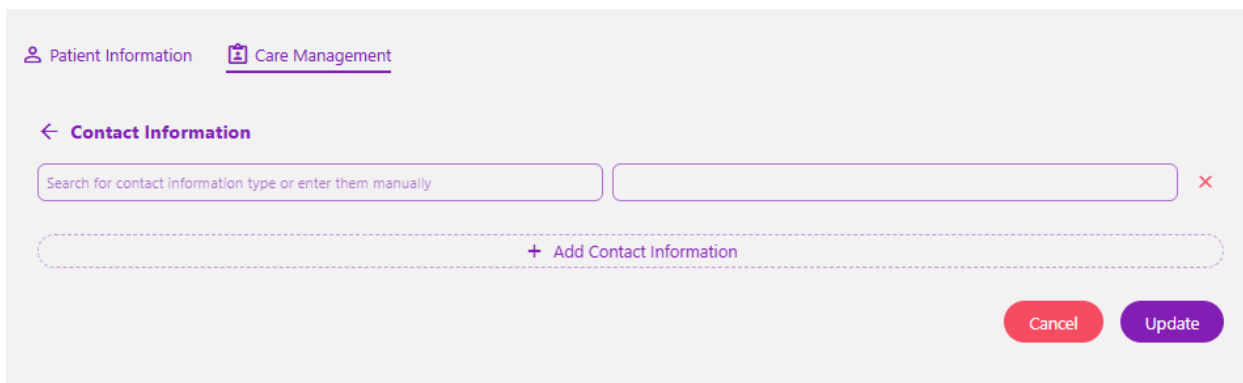


Once a Team member has accepted, you can make them an Admin to the account. This will allow them to make changes to the Care Plan.



4.3 Contact Information

In this section the Admin can provide details for anyone relevant in the Care team. This could be Medical Specialists, Family members etc. You can add contact details such as office addresses, email addresses or phone numbers etc.



4.4. Other information

This section is highly customisable and it is up to the user to add in as many or as few sections as they want. Some categories are recommended but this area is fully customisable by creating titles and entering into a free text field.

All the information entered here will be visible on the Care Plan in the Caretaker mode.



< Other Information

Search for other information type or enter them manually...



Enter notes...

[+ Add Other Information](#)

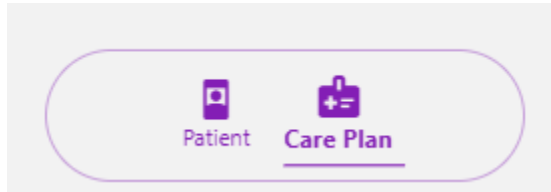
Cancel

Update



5. Care Plan setup

The Care Plan setup can be entered via the controls at the bottom selecting the “Care Plan” section. It is the programming of the care taker mode in the app/platform.



5.1 General Observations

General observations allow the user to make free text entries that will appear in the Care Plan. The admin can also select all relevant data points for the vitals.

5.1.1 Temperature

It is recommended to note the patient's baseline temperature and other relevant notes.

5.1.2 Pain

The Admin can note what signs of pain are and what the response actions are. This is particularly helpful for non-verbal patients who might not be able to express and explain their pain as easily.

5.1.3 Height and Weight

This is a free text field where the user might note recommended intervals of height and weight checks or where a goal weight is added.



5.1.4 Vitals

The admin can select which data points they would like record routinely for the patient.

The possible data points include:

- Heart rate
- O2 Saturation
- Respiratory Rate
- Work of Breathing
- O2 Therapy
- Awake/Asleep
- Probe changes

The admin can also create a schedule on how regular they would like to take vitals. These times will appear in the schedule. The care takers can however take vitals more frequently then this.

The admin can also add additional notes in the Free text field that will the appear in the Care Plan.

The screenshot shows a user interface for configuring vitals for a patient named John. At the top, there are navigation icons for Temperature, Pain, Height and Weight, and Vitals (which is selected). Below this is a 'Record' section with a list of vitals: Heart Rate, O2 Saturation, Respiratory Rate, Work of Breathing, O2 Therapy, Awake/Asleep, and Probe Change, each with a checked checkbox. A 'Schedule' section is also present, showing a frequency of 'Daily' and two time slots: 10:00 and 22:00. There is an 'Add Time Slot' button and a summary of the schedule: 'Every day at 10:00, 22:00'. At the bottom, there is a 'Notes' section with a text input field.



4.2 Activities of Daily Living

4.2.1 Scheduled and PRN Medications

The Admin can setup Regular Medications as well as PRN Medications for each patient. A generic notes section give room for general rules around Medication administration.

The screenshot shows a user interface for managing a patient's activities of daily living. At the top, the patient's name 'John' is displayed with a profile icon. Navigation icons for 'Home' and 'Logout' are in the top right. Below the patient name, there is a section titled 'Activities of Daily Living' with a back arrow. Underneath, there are four category icons: 'Medication' (selected), 'Nutrition', 'Toileting', and 'Sleep'. The 'Medication' section is divided into two parts: 'Regular' and 'PRN'. Each part has an 'Add' button. The 'Regular' section shows a card for 'Medication 1 - 100mg' with details: 'Dosages: 100mg', 'Route: Transdermal', and a schedule of 'Every day at 07:00, 19:00'. The 'PRN' section shows a card for 'Paracetamol' with details: 'Indication: Pain', 'Can be repeated after: 6 hours', 'Doses in 24 hours: 4 doses', 'Dosages: 500mg', and 'Route: PEG'. At the bottom, there is a 'Notes' section with a large empty text area.



Regular Medications

For each regular medication the Admin enters the name of the medication, the dosage, the Route of Administration and the schedule.

The schedule can be daily, weekly, monthly or otherwise in a custom manner. In addition the admin selects the time(s) when each medication is due. The admin can select an optional end date for the medication.

← Activities of Daily Living

Medication Nutrition Toileting Sleep

← Add Regular Medication

Medication*

Dosages*

Route of Administration

Search for routes of administration or enter them manually

Schedule

Frequency

Daily Weekly Monthly Custom

Set Time Slots

00:00

+ Add Time Slot

Has end date?

Every day at 00:00

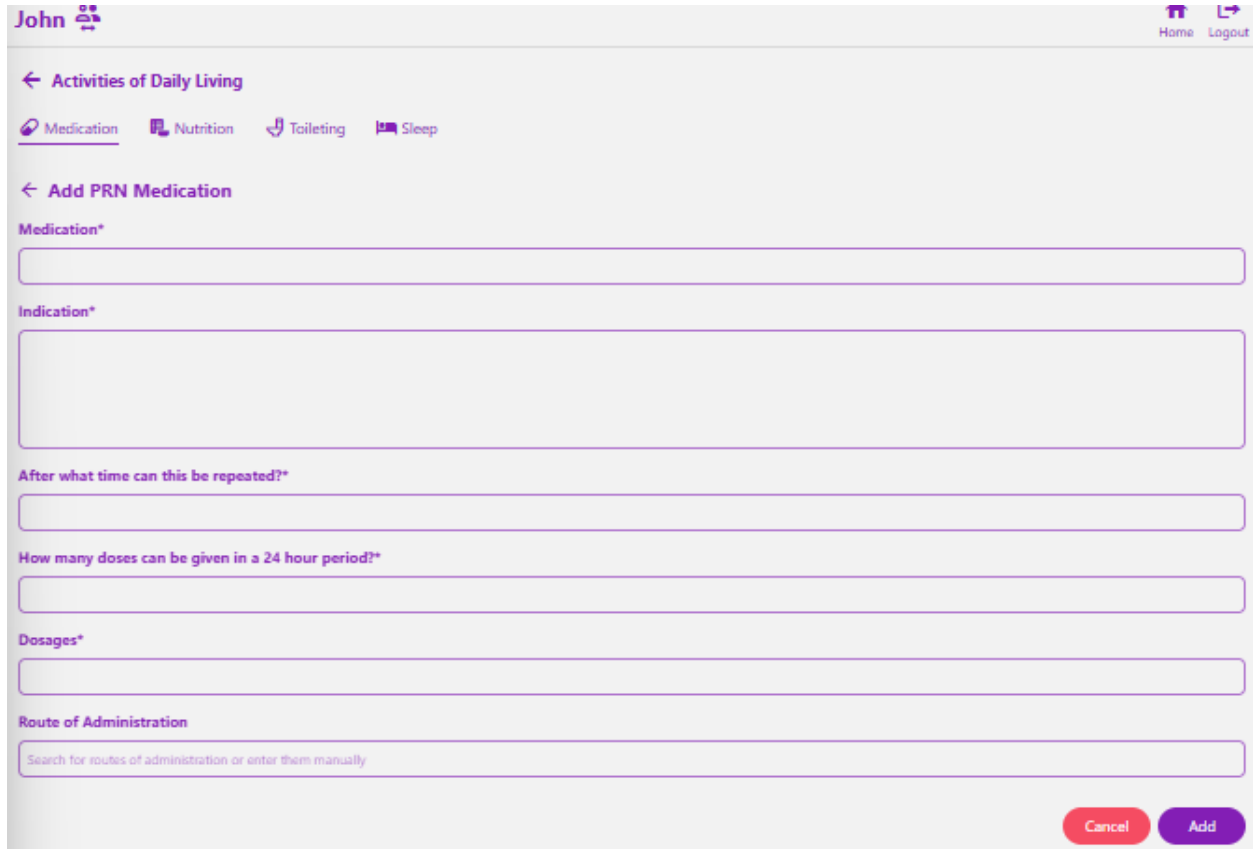
Cancel Add

The regular medications will appear in the Daily schedule as well as part of a medication chart in the Care Plan.



PRN Medications

For PRN Medications the Admin selects the Medication name, the indication of when to administer the medication, the amount of time when the PRN medication can be repeated, how many doses can be given in a 24 hour period, the dosage and the Route of Administration.



The screenshot shows a user interface for adding a PRN medication. At the top, the user's name 'John' is displayed with a profile icon, and navigation links for 'Home' and 'Logout' are visible. Below this, a breadcrumb trail shows 'Activities of Daily Living' with a back arrow, and sub-categories for 'Medication', 'Nutrition', 'Toileting', and 'Sleep'. The main heading is 'Add PRN Medication' with a back arrow. The form consists of several input fields: 'Medication*' (a text box), 'Indication*' (a larger text area), 'After what time can this be repeated?*' (a text box), 'How many doses can be given in a 24 hour period?*' (a text box), 'Dosages*' (a text box), and 'Route of Administration' (a search box with the placeholder text 'Search for routes of administration or enter them manually'). At the bottom right, there are two buttons: a red 'Cancel' button and a purple 'Add' button.

The PRN medications will appear in the Care Taker view as a list of medications, the information entered for each Medication will appear in the entry screen and also in the Care Plan.



4.2.2 Nutrition

The nutrition section is mostly targeted towards patients who rely on tube-feeding. An oral option is also available for users that can eat or drink orally. The admin can also add general notes regarding nutrition in the Free text field for notes which will appear in the Care Plan.

As a first step, the Admin should setup one or multiple Recipes:

The screenshot shows a web interface for a patient named John. At the top, there are navigation icons for Home and Logout. Below the patient name, there is a section titled 'Activities of Daily Living' with sub-tabs for Medication, Nutrition (selected), Toileting, and Sleep. Under the Nutrition tab, there are four buttons: 'Recipes' (highlighted in purple), 'Bolus', 'Oral', and 'Continuous'. Below these buttons is a form titled 'Add Recipe'. The form contains three input fields: 'Name*' (a single-line text box), 'Recipe*' (a large multi-line text box), and 'Please specify what you use for flushes*' (another large multi-line text box). At the bottom right of the form are two buttons: 'Cancel' (red) and 'Add' (purple).

Then the user selects which feed regime the patient follows - Bolus Feeds, Continuous Feeds, oral intake.



For Bolus feeds the Admin needs to select one or multiple timeslets for each recipe, the feed volume, the feed rate and the Route of Administration.

This will create tasks in the scheduler and will also appear in the Nursing Care Plan.

The screenshot shows a mobile application interface for adding a bolus feed. At the top, the user's name 'John' is displayed. Below that, there are navigation options for 'Home' and 'Logout'. The main section is titled 'Activities of Daily Living' and includes tabs for 'Medication', 'Nutrition', 'Toileting', and 'Sleep'. Under 'Nutrition', there are sub-tabs for 'Recipes', 'Bolus', 'Oral', 'Continuous', and 'Notes'. The 'Bolus' tab is currently selected. The 'Add Bolus Feed' form contains the following fields:

- Time***: A section with a 'Frequency' dropdown set to 'Daily', a 'Set Time Slot' input field containing '00:00', and a note 'Every day at 00:00'.
- Recipe***: A dropdown menu with 'Select' as the current option.
- Feed Volume***: A text input field with 'ml' as the unit.
- Feed Rate***: A text input field with 'ml/hr' as the unit.
- Route of Administration**: A search input field with the placeholder text 'Search for routes of administration or enter them manually'.

At the bottom right of the form, there are two buttons: a red 'Cancel' button and a purple 'Add' button.



For an oral feeding regime, the Admin can select timeslots and recipes.





The screenshot shows a mobile application interface for 'Activities of Daily Living'. At the top, there are navigation icons for Medication, Nutrition, Toileting, and Sleep. Below this is a horizontal menu with tabs for Recipes, Bolus, Oral (which is selected and highlighted in purple), Continuous, and Notes. The main content area is titled 'Add Oral Feed'. It contains a form with the following fields: 'Time*' (with a sub-section for Frequency set to 'Daily', Set Time Slot set to '00:00', and a note 'Every day at 00:00'), and 'Recipe*' (a dropdown menu currently showing 'Select'). At the bottom right of the form are two buttons: 'Cancel' (red) and 'Add' (purple).

For a continuous feeding regime the admin is required to fill in a form regarding the continuous feed regime, including the following:

- total Feed volume in a 24 hour period
- Maximum Feed rate
- Recipe
- Route of Administration for feeds
- Interval of Flushes in minutes
- Flush volume
- Route of Administration for flushes
- Times to record feed and flush volume for the day.
- Time to reset the feed count.



← Activities of Daily Living

-  Medication
-  **Nutrition**
-  Toileting
-  Sleep

Recipes Bolus Oral **Continuous** Notes

Does patient receive continuous feeds?*

How much feed volume do you aim for a 24 hour period?

ml

What is the maximum feed rate?

ml/hr

Which recipe do you feed?*

▾

Route of Administration

×

How often do you need to flush during the feed?

Every minutes

What is the flush volume?

ml

Which route of administration do you use to flush the patient?

×

What times do you want to record the total feed and/or flush volume for the day?*

Frequency

Daily

Set Time Slots

+ Add Time Slot

 Every day

 at 20:00

When do you want to reset the total count?*

Frequency

Daily

Set Time Slot

 Every day

 at 00:00



4.2.3 Toileting

Recognising that some patients need more information on toileting habits than others, the toileting section can be customised to the patients needs. The following data points can be selected for the observation entry form in addition to passed urine and bowels open:

- Urine quantity
- Urine smell
- Urine colour
- Stool quantity
- Stool consistency
- Stool colour

The Admin can also advise if the Patient requires catheters, which type and size and the frequency for catheterisation.

You can select of suppositories and enemas need recording as well as bowel washouts and what the time of intervention would be when there is lack of bowel movements.

At the end of the setup is a Notes section that allows the user to enter any additional information.

John

← **Activities of Daily Living**

Medication Nutrition **Toileting** Sleep

Would you like to record more details other than P/U and/or B/O for toileting?*

Please specify what you would like to record.

- Urine quantity
- Urine smell
- Urine colour
- Stool quantity
- Stool consistency
- Stool colour

Do you use catheters?

Yes No

Please specify your Catheter type

Please specify your Catheter size

Please specify rough frequency for catheterisation in hours

hours

Do you need to record the use of Enemas or suppositories?

Yes No

Please specify after how many hours of lacking bowel movement you would implement an intervention.

hours

Do you need to record the use of bowel washouts?

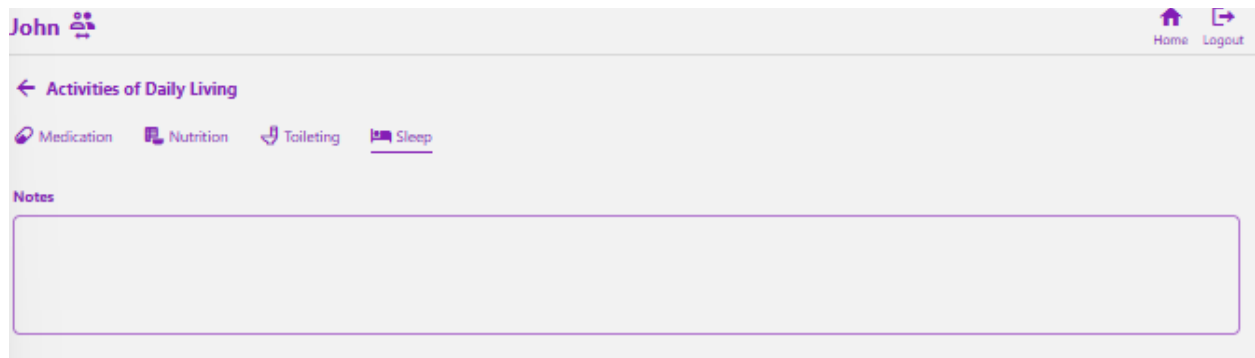
Yes No

Would you like to add any other notes for toileting for the Nursing Care Plan?



4.2.4 Sleep

It is recommended to describe the patient's normal sleep routine in the Notes section. This will display in the Care Plan.

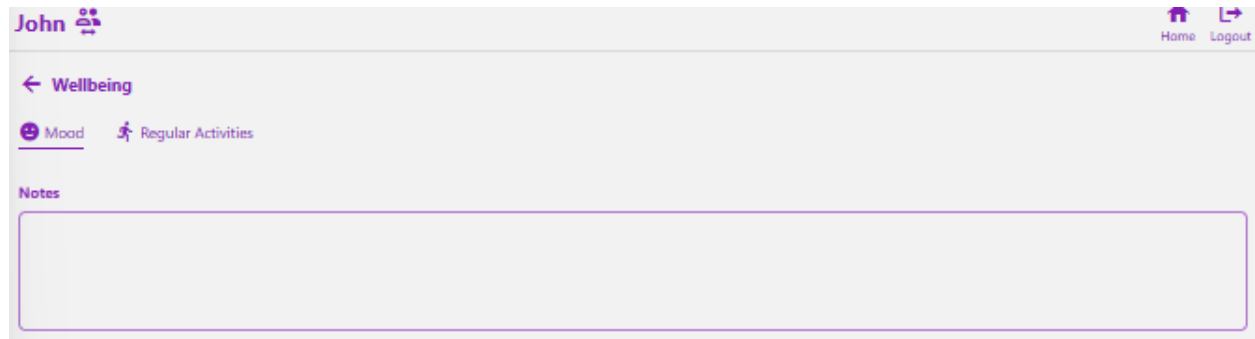


The screenshot shows a mobile application interface for a patient named John. At the top, there is a header with the name 'John' and a profile icon on the left, and 'Home' and 'Logout' buttons on the right. Below the header is a navigation bar with a back arrow and the title 'Activities of Daily Living'. Underneath, there are four icons representing different categories: Medication, Nutrition, Toileting, and Sleep. The 'Sleep' icon is highlighted with a purple underline. Below the navigation bar is a section titled 'Notes' with a large, empty rectangular text input area.

4.3 Wellbeing

4.3.1 Mood

It is recommended to describe the patient's normal mood as well as signs to look out for with regards to their mood in the Notes section. This will display in the Care Plan.



The screenshot shows a mobile application interface for a patient named John. At the top, there is a header with the name 'John' and a profile icon on the left, and 'Home' and 'Logout' buttons on the right. Below the header is a navigation bar with a back arrow and the title 'Wellbeing'. Underneath, there are two icons representing different categories: Mood and Regular Activities. The 'Mood' icon is highlighted with a purple underline. Below the navigation bar is a section titled 'Notes' with a large, empty rectangular text input area.



4.3.2 Regular Activities

Regular activities can be set up in the same way as Medications. The user selects or describes the Activity and chooses a frequency (daily, weekly, monthly custom) as well as (multiple) timeslot. Typical activities can be matters of daily hygiene or regular cleaning of equipment, changes of filters on equipment or bedsheets. This is highly customisable to the person's needs.

In the notes section the Admin can leave additional information or instructions that will appear in the Care Plan.

The screenshot shows a form titled "Activity" with a search bar at the top. Below the search bar is a "Schedule" section containing several controls: a "Frequency" section with four buttons labeled "Daily", "Weekly", "Monthly", and "Custom"; a "Set Time Slots" section with a time input field showing "00:00" and a "+ Add Time Slot" button; and a summary section showing a calendar icon, "Every day", and a clock icon, "at 00:00". A "+ Add" button is located at the bottom right of the form. Below the form is a text area with the prompt "Do you have any additional notes to add to the Daily Activities section of the Nursing Care Plan?".



4.4 Neurological

4.4.1 Seizures

In order to customise the seizures entry form, the Admin needs to select the types of seizures and what the PRN time limit is for each seizure type. When the care taker enters a seizure and selects the seizure type the PRN time limit will display.

The Admin can also select various Triggers for seizures to display on the entry form. It is recommended to create a “NA” or “unsure” option when the trigger cannot be identified.

The notes field allows the admin to enter any additional information relating to seizures, such as how to comfort the person during a seizure or how to support in the post ictal phase.

The screenshot shows a user interface for configuring seizures. At the top, the user is identified as 'John' with a profile icon. Navigation links for 'Home' and 'Logout' are in the top right. A breadcrumb trail shows 'Neurology' with a back arrow. Below this, there are tabs for 'Seizures' (active) and 'Movements'. The main section is titled 'Seizures' and includes a sub-header: 'Use the form below to add seizure to the seizures section of your nursing care plan.' There is a list of existing seizure types: 'Tonic Clonic' with a 'PRN time limit: 5 minutes' and a red 'X' icon. Below this is a form for adding a new seizure, with a search bar labeled 'Search for seizures you would like to add or enter them manually', a 'Time Limit for PRN' field with a 'minutes' label, and a '+ Add' button. The next section is 'Triggers', with the sub-header: 'Use the form below to add triggers to the seizures section of your nursing care plan.' It contains a list of existing triggers: 'Sleep Transition' and 'Noise', each with a red 'X' icon. Below this is a form for adding a new trigger, with a search bar labeled 'Search for trigger you would like to add or enter them manually' and a '+ Add' button. At the bottom, there is a 'Notes' section with a large text area.



4.4.2 Movements

For movements the Admin adds any movement types that the patient is known to experience and also a time limit for PRN medications.

The notes field allows the admin to enter any additional information relating to movements, including but not limited to on how to comfort during movements.

The screenshot shows a web interface for a patient named John. The page is titled 'Neurology' and has two sub-sections: 'Seizures' and 'Movements'. The 'Movements' section is active and contains a form with the following fields:

- Movement:** A search bar with the placeholder text 'Search for movement you would like to add or enter them manually'.
- Time Limit for PRN:** A text input field followed by the label 'minutes'.
- + Add:** A purple button to submit the form.
- Notes:** A large, empty text area for additional information.

At the top right of the page, there are links for 'Home' and 'Logout'.



4.5 Gastroenterology

4.5.1 BSL & Ketones

If the patient needs tracking of BSL and/or Ketones, the Admin can select one or both of them and also select the intervals of routine tracking in the scheduler. The scheduled times will appear in the scheduler in the Care taker mode ensuring that BSL and/or Ketones are tracked routinely.

In the notes section the Admin should outline additional information such as the equipment to use for checks, highlight possible sensitivities and state the values to aim for.

The screenshot shows a user interface for scheduling BSL and Ketone tests. At the top, the user's name 'John' is displayed. The page title is 'Gastroenterology'. Below this, there is a section for 'BSL and Ketones' with two checked checkboxes: 'BSL' and 'Ketones'. A 'Schedule' section allows the user to choose a frequency: 'Daily' (selected), 'Weekly', 'Monthly', or 'Custom'. Under 'Set Time Slots', there is a text input field containing '16:00' and a '+ Add Time Slot' button. Below the schedule section, there is a text area for 'Any other general notes relating to Gastroenterology?'.



4.6 Respiratory

4.6.1 O2 Therapy

On O2 Therapy the Admin can select which methods of O2 Therapy are being used for the patient. The setup form also asks for the minimum O2 Saturation for the patient.

The Admin can also select multiple optional data points for the O2 Therapy that need tracking:

- FiO2
- PEEP
- PiP
- Rate/Min
- Inspiration Time
- VTE
- High PIP Alarm
- VE



- Volume

The screenshot shows a web interface for a respiratory care plan. At the top, there is a navigation bar with a back arrow and the title 'Respiratory'. Below this are three tabs: 'O2 Therapy' (selected), 'Suctioning', and 'Chest Physio'. The main heading is 'Which methods of O2 Therapy Delivery do you use?' with a sub-note: 'Use the form below to add therapy to the O2 Therapy Delivery section of your nursing care plan.' There are two input fields for delivery methods, each containing text and a red 'X' delete icon. The first field contains 'Hudson Mask' and the second contains 'Room Air'. Below these is a section titled 'O2 Therapy' with a search bar containing the placeholder text 'Search for therapies you would like to add or enter them manually' and a '+ Add' button. The next section asks 'What is the minimum O2 Saturation limit for the patient?' with an input field containing '92' and a '%' symbol. The final section is 'What other observations would you like to record?' with a list of checkboxes: FIO2, PEEP (checked), PIP, Rate/Min, Inspiration Time, VTE, High PIP Alarm, VE, and Volume. At the bottom, there is a text area for 'Would you like to add any other notes for the Nursing Care plan with regards to Oxygen Therapy?'.

As a standard the Care taker Observation form requests the Flow rate.

In the Notes and additional information can be entered.




Tip: The Admin might want to create the O2 Therapy Method “RoomAir” to allow the Caretakers in the observation mode to indicate when other O2 Therapies are removed.

4.6.2 Suctioning

In the notes section for suctioning the Admin should outline additional information such as the equipment to use, how to use deepsuction, e.g. oral or nasal, any other preferences, brand of suction catheters etc.



← Respiratory




 O2 Therapy  Suctioning  Chest Physio

Would you like to add any other notes for the Nursing Care plan with regards to Suctioning?

4.6.3 Chest Physio

In the notes section for Chest Physio the Admin should outline information such as duration of chest physio sessions, regularity, indications when to use Chest Physio etc.

← Respiratory

 O2 Therapy  Suctioning  Chest Physio

Would you like to add any other notes for the Nursing Care plan with regards to Chest Physio?



4.7 Allied Health

4.7.1 Equipment

The Admin can specify any equipment that is being used for Allied Health purposes, e.g. Standing Frames, walkers, alternative seating options, speech therapy tools like eye gaze or Pods etc. The equipment added will appear in a selection box for the observation entry.

The notes section should contain information such as duration of recommended use, intervals for use or other instructions. This information will appear in the Care Plan.

The screenshot shows a web interface for managing equipment. At the top, there is a navigation bar with a back arrow and the text 'Allied Health'. Below this is a sub-section titled 'Use of Equipment' with a gear icon. The main content area is titled 'Equipments' and includes the instruction: 'Use the form below to add equipments to your nursing care plan.' There are two existing equipment entries, each in a light blue box with a red 'X' in the top right corner: 'Standing Frame' and 'Occupational Therapy'. Below these is a section titled 'Equipment' which contains a search input field with the placeholder text 'Search for equipment you would like to add or enter them manually' and a red 'X' in the top right corner. A blue '+ Add' button is located at the bottom right of this section. At the bottom of the form is a 'Notes' section, which is currently empty.



4.8 Positive Behaviour Supports

4.8.1 Positive Behaviour Supports

The Admin can make some notes on the Positive Behaviour supports in place. The following selections can be made:

Selection of the PBS Phase:

- Interim Behaviour Support Plan
- Comprehensive Behaviour Support Plan
- Maintenance Behaviour Support Plan

Selection of Risk Markers (Low - Moderate - High)

Restrictive Behaviours in use (Optional).

The Admin can then provide some generic guidance on Positive Behaviour Supports which will appear in the Care Plan.

Tip: It is strongly recommended to upload the full Behaviour Support Plan in the File section.

The screenshot shows a web interface for configuring a Positive Behaviour Support plan. At the top left, the user is identified as 'John'. The page title is 'Positive Behaviour Support'. Below the title, there is a breadcrumb link 'Positive Behaviour Support'. The main content area is titled 'Positive Behaviour Support Plan' with a subtitle 'Configure the Positive Behaviour Support plan details including phase, risk level, and any restricted practices.' There are three main sections: 1. 'PBS Phase' with a dropdown menu currently set to 'Maintenance Behaviour Support Plan'. 2. 'Risk Marker' with a dropdown menu currently set to 'Low'. 3. 'Restricted Practices (Optional)' with four checkboxes: 'Physical restraint', 'Seclusion', 'Chemical restraint', 'Mechanical restraint', and 'Environmental restraint', all of which are currently unchecked. Below these sections is a large text area for 'Baseline Notes (Optional)'. At the bottom of the page, there is a light blue footer note: 'Please provide some generic instructions here. We strongly recommend uploading the full PBS plan via the file share option in the Caretaker mode.'

