Goal Directed Care Planning

Frequently Asked Questions

Do I need to set goals with every client?

While setting goals is a valuable tool for many clients, formal goal setting isn't appropriate or meaningful for everyone. Circumstances where formal goal setting may not be appropriate include when:

- **The client has recently undergone a holistic assessment and GDCP process**

  If you are aware that the client has recently complete a holistic assessment (either with another member or your team, another discipline or another service), then it is important not to duplicate that process. Instead you may focus on clarifying the specific goals within your program and just ask whether there are any other issues they would like support with.

- **the client is in crisis, acutely psychotic or highly anxious**

  In these circumstances, you often need to focus on your intervention first, sort out the critical issues and build trust / rapport. It may be appropriate to come back to discuss formal goals in the future once the crisis has resolved or the client's mental state has improved.

- **The client is attending your service for a one-off single intervention**

  This may include if a client attends a screening program or a one-off community education session. Please note however, that if issues are identified during that session that require ongoing support, the staff member would refer on to complete a full assessment and GDCP.

It is important to note however, that the decision about goal setting should never be driven by someone's diagnosis or prognosis. For example, while your approach to GDCP will be different for clients who have dementia or are receiving palliative care, you wouldn't automatically rule someone out because of these factors.

When a client is unable to articulate a goal themselves (e.g. due to cognitive impairment, age or disability), it is important to recognise that:

- within HACC services, carers are also considered our clients. The goals of carers are therefore equally important in the GDCP process.
- the way we deliver services, should always reflect the client's interests, values and preferences. Staff therefore have a responsibility to understand the client and tailor the services accordingly.

Staff need to be supported by systems that allow them to use their professional judgement to determine whether goal setting is appropriate for their client. Agencies need to ensure that their policies and procedures support this practice and describe the process for documenting when formal goals have not been set.

This resource was jointly funded by the Commonwealth and Victorian Governments

Goal Directed Care Planning

Frequently Asked Questions

What can I do when a client has trouble identifying a goal?

While staff use the word "goal", this language is often meaningless for our clients. For many clients (particularly older people and people from different cultures), the concept of setting goals and being involved in making decisions about their care, is unfamiliar. It is still important though, to understand what is important to the client and ask them what they want to achieve.

Instead of asking clients "what are your goals?" try asking the question in different ways. For example:

- *What are you hoping to achieve by working together?*
- *What's most important to you?*
- *How can we best support you?*
- *What are the things that you would like us to focus on?*

If a client is still having difficulty identifying their goals, pick up on cues from your conversation and use these as prompts for further conversation. For example:

You have spoken a lot about feeling lonely at home alone …

- *Is this something you would like to work on changing?*
- *Is there a way that we can support you with this?*
- *What do you think would help you to feel less lonely?*

Remember also, that formal goals don't need to be set within the first session. It may be useful to give people time to think about what they want, or try out a service so they understand more about it. You can then come back to set formal goals at a later time. You may also start by identifying one small goal, then over time, as the client becomes more familiar with the service, other goals may be added or refined.

What do I do when a client sets a goal that has nothing to do with what my agency offers?

Just because a client identifies a goal, does not mean that you are responsible for achieving it. For example, a client may say they want to travel to Egypt to visit the Pyramids. It is not your responsibility to organise their travel arrangements! Instead, you should ask the client whether there is a way that you can support them with this? There may not be, and that's ok – goal setting is a strategy to empower people to make decisions and manage their own lives, therefore you don't need to be responsible for, or involved in, achieving every goal. The client may choose to document this as a goal on their care plan and the actions may describe that they are going to organise the trip with support from their family.

Alternatively, the client may tell you that the reason they haven't organised their trip is because they don't feel strong enough to manage the large amount of walking. You could then suggest making a referral to a physiotherapist who can support them to build up their endurance.

Also, remember that if you identify that a client has complex issues or concerns that are beyond the scope of your role (or service), it may be appropriate to refer the client to a HACC Assessment Service (HAS). These services are specifically funded to conduct Living At Home Assessments (LAHA) with clients and will be able to link the client in to a range of supports to meet their needs.

Goal Directed Care Planning

Frequently Asked Questions

Why do I need to set individual goals for my clients when we work in a group setting?

While a number of people may participate in a group program, the reasons why they are there and what they hope to achieve, will be different for each person. Developing a GDCP is a strategy to identify these reasons for each participant and allows you to ensure that each person is getting the most out of the program.

For example, you may run a group program that is designed to bring people together to socialise. While we may consider this as a strategy to reduce social isolation, it is unlikely that a client would describe their goal as "socialisation". Instead, they may describe wanting *to make friends, spend time with people my own age or going on regular outings.* These would then become the clients' goals. Once we understand what the person wants to achieve, we can then ensure that the group program is meeting that need and identify whether any other supports are required.

I offer my clients a copy of their care plan, but they don't want it.

For a GDCP to become a valuable for your client, you need to ensure that:

- The information in the care plan is legible, meaningful to the client and written in simple, easy to understand language.
- When discussing the person's care plan, be clear about why you are giving it to them and talk to them about how they can use it.

For example: *"This care plan is a simple summary of how we are going to work together. It includes information about the things that you want to work on and is a useful reminder of what each of us has agreed to do. Over time, we will use your care plan to check back in and make sure that you are getting the most out of our program. Your care plan is also an easy way for you to let other people know about how we are working together. You may want to share it with your family and take it along to other appointments so that you don't have to remember everything off the top of your head."*

I already write all this information on another form, why do I have to complete a GDCP?

A GDCP is a tool for the client. Rather than documenting the same information multiple times, it is important to look at how you can streamline your tools and reduce duplication wherever possible. It is important to share the GDCP with the people involved in delivering the care with the person's consent (e.g. Direct Care Staff, Volunteers, Carers). By sharing the GDCP, you should not need to duplicate this information on other paperwork.

When reviewing documentation:

- ensure that the staff who use the tools are involved in the review
- trial any changes you make and continue to refine your tools as you learn about what will work best in the context of your agency
- obtain feedback from your clients, carers and other staff members about your forms
- make sure your organisational policies and procedures clearly describe your documentation processes.

This resource was jointly funded by the Commonwealth and Victorian Governments