Audit Tool for Care Planning Templates

Organisation / Team: _____ Audit Date: _____

Name of template being audited: _____ Audit Completed by: _____

Audit Criteria	Rationale	Scale
The care planning template provides clear space to document:		
1. The date of completion of the care plan	Readers should be able to quickly identify when the care plan was completed.	1 – Yes 0 – No
2. The people involved in the development of the care plan	Person centred care highlights the importance of actively engaging the client and other relevant people (including carers, friends, family and other service providers) in the development and review of the care plan. The names of the people involved in care planning should be clearly documented (including roles of and organisations where relevant)	1 – Yes 0 – No
3. The client's current context / current situation	Provide space to document a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This articulates the relevance of each goal within the context of the person's life and enables effective follow up and review. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns In order to reinforce a strengths based approach, documenting 'current context' or 'current situation is preferable (rather than an issues list or problems list)	1 – Yes 0 – No
4. The client's goals (what the client hopes to achieve)	Clearly defined goals are essential to drive the development of the care plan. Alternative headings such as 'what are we aiming for', 'what I want to achieve' or 'I want to…" can be used instead of the word goal	1 – Yes 0 – No
5. The actions required to achieve each goal	Actions are the key steps required to achieve a goal. This should include actions to be completed by staff, the client, carers etc.	1 – Yes 0 – No
6. The format makes it clear which actions relate to each goal	Actions support the achievement of goals and therefore the two need to be clearly linked	1 – Yes 0 – No
7. The person / people responsible for implementing each action	In order to demonstrate clear accountability, a specific person should be assigned responsible for each action. In order to support a collaborative approach, it is important to document the actions to be completed by staff, the client, carers and other relevant team members	1 – Yes 0 – No
8. The date / timeframe within which each action will be completed	Specific timeframes should be developed in accordance with the client's needs and priorities and articulated for each action. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process. Include names where possible.	1 – Yes 0 – No
9. Who the care plan will be provided to	Once a care plan has been developed it is important to communicate the final plan to all relevant parties (including the client, carers, relevant staff and other agencies involved in the client's care)	1 – Yes 0 – No
10. A date for the review of the care plan	Care plans should be regularly reviewed so that the goals and associated actions remain current and relevant	1 – Yes 0 – No
11. Client acknowledgement	The client should sign the care plan, acknowledging that they have been actively involved in the development of the care plan and that they are happy with the information and actions included	1 – Yes 0 – No
TOTAL		/ 11

Developed as part of the EMR HACC GDCP Project