# Goal Directed Care Planning Toolkit:

Practical strategies to support effective goal setting and care planning with HACC clients

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This toolkit was developed based on the work conducted within the EMR HACC Alliance.

This project was supported by funding from the Commonwealth and Victorian Governments under the HACC program.



This document and the associated resources are available on the internet at our local Primary Care Partnership (PCP) websites:

http://www.iepcp.org.au/active-service-model-emr-hacc-alliance or
http://www.oehcsa.org.au/special-project

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# Foreword

New policy and planning frameworks implemented across Victoria's HACC sector (including the Active Service Model, Diversity Planning and Practice, HACC assessment framework and the new Common Community Care Standards) has seen a significant shift in the way Home and Community Care (HACC) services are delivered. The focus of care is very clearly focussed on services that are flexible and tailored to the needs of each client. Goal Directed Care Planning provides a solid foundation to deliver this person centred approach and is essential in our ability to support people living in the community in meaningful ways. A client focussed approach has long been supported 'in principle' in the region, however there have been many challenges in our ability to design service solutions that recognise each person's needs and priorities.

In Melbourne's Eastern Metropolitan Region (EMR), staff members across our local HACC agencies have come together through the EMR HACC Alliance, with support from the Department of Health Regional office, to work collaboratively to understand these issues, share expertise and experiences and develop effective solutions. Development of this Goal Directed Care Planning Toolkit is one of many examples of the great partnership work being conducted with support from the Alliance. The willingness of agencies to participate in this project has exceeded all expectations and I commend the sector's commitment and investment in this initiative.

I am very pleased, on behalf of the EMR HACC Alliance, to present the Eastern Metropolitan Region's HACC Goal Directed Care Planning Toolkit – a practical and user-friendly guide to developing and embedding effective goal setting and care planning strategies. The toolkit recognises that effective practice change is only successful when support across all levels of the organisation is provided to enable them to work in this way.
It provides clear guidelines about how we can all work together in order to achieve great results.

We are confident that this toolkit will build on the good practice that is occurring in the region and be a valuable resource for many sectors, supporting staff to deliver quality, person centred care for our community.

**Martin Wischer**
**Chair EMR HACC Alliance Executive**

# Acknowledgements

This toolkit is the culmination of many people's hard work, enthusiasm and commitment over the last 18 months. The design and implementation of the EMR HACC Goal Directed Care Planning (GDCP) project has largely been driven by members of the Eastern Metropolitan Region's HACC Alliance, which has provided a forum for local HACC agencies to come together, share their experience and work collaboratively to support quality improvement across the sector. Thank you to the Alliance's Executive Group for their leadership and to all Alliance members for their ideas and feedback.

The project brought together 56 staff from 39 local HACC agencies, each of which shared their expertise, experience and time openly and generously. Their involvement in this project is just one example of their commitment to ongoing learning in order to deliver the best possible services to our community. Thank you for your continued dedication, time and energy, for your openness, enthusiasm and ideas, for spreading the word and becoming champions within your teams.

This project was supported by funding from the Commonwealth and Victorian Governments under the HACC program. Thank you to the Department of Health Eastern Metropolitan Region (DH EMR) HACC team who provided leadership and support throughout the project and to the Central Office staff who have been actively involved in the drafting and review of this toolkit. The toolkit contains information from a range of best practice resources and builds on a wealth of research and person centred tools. Most significantly, the tools provided in Chapter 2 include person centred concepts, principles and materials used with permission from the Learning Community for Person Centred Practices (www.learningcommunity.us) and Helen Sanderson Associates (http://www.helensandersonassociates.co.uk). These tools provide staff with practical, easy to understand strategies to support GDCP and have been invaluable in this project.

We gratefully acknowledge the input of all the staff, clients and carers of the following organisations for your contributions throughout the project– the value of this resource is thanks to you.

| | | |
|---|---|---|
| Yarra Ranges Council | Caladenia Dementia Care | Ranges Community Health Service |
| Villa Maria | EMR Palliative Care Consortium | Royal District Nursing Service |
| MS Australia | Eastern Palliative Care | Department of Health – Central Office |
| Baptcare | Department of Health – EMR | Inner East Community Health Service |
| Eastern Health | Helen Sanderson Associates | Knox Community Health Service |
| Care Connect | Maroondah City Council | Uniting Care Community Options |
| City of Monash | Interchange Inner East | Australian Greek Welfare Society |
| City of Whitehorse | St Vincents at Home | Whitehorse Community Health Service |
| Glencare Wavecare | Manningham Centre Association | Anglicare Victoria – Dixon House |
| Doncare | Manningham City Council | Manningham Community Health Service |
| DutchCare | Uniting Aged Care | Inner East Primary Care Partnership |
| EACH | Balwyn Welfare Association | Outer Eastern Health & Community Services Alliance |
| Knox City Council | Samarinda Aged Services | |

**Kate Pascale**
**Director, Kate Pascale and Associates**

# Glossary

| | |
|---|---|
| **ACAS** | Aged Care Assessment Service |
| **ASM** | Active Service Model |
| **CALD** | Culturally And Linguistically Diverse |
| **CCCS** | Community Care Common Standards |
| **CHS** | Community Health Service |
| **CIF** | Continuous Improvement Framework (a resource of the Victorian Service Coordination Practice Manual) |
| **DH** | Department of Health |
| **EMR** | Eastern Metropolitan Region |
| **GDCP** | Goal Directed Care Plan / Planning |
| **HACC** | Home And Community Care |
| **HAS** | Home And Community Care (HACC) Assessment Service |
| **HR** | Human Resources |
| **IEPCP** | Inner East Primary Care Partnership |
| **LGA** | Local Government Area |
| **OEHCSA** | Outer East Health and Community Support Alliance (The Outer Eastern Region's Primary Care Partnership) |
| **PAG** | Planned Activity Group |
| **PCP** | Primary Care Partnership |
| **SCTT** | Service Coordination Tool Templates |
| **SMART goals** | Specific, Measurable, Achievable (or Attainable), Relevant (or Realistic) Time-limited (or Time bound / Time based) goals |
| **VHA** | Victorian Healthcare Association |
| **VSCPM** | Victorian Service Coordination Practice Manual |

# Contents

# Introduction and Background

In Melbourne's Eastern Metropolitan Region (EMR), developing Goal Directed Care Planning (GDCP) practices was identified by local Home and Community Care (HACC) agencies as a priority to support the implementation of the Active Service Model (ASM). While a range of goal setting and care planning approaches were already in place, staff reported varying levels of confidence about their efficacy and requested education and support to build their capacity for effective, evidence based GDCP. Project funding was successfully sought through the Victorian Department of Health, ASM seeding grants. The project was coordinated through the EMR HACC Alliance[1] and led by Kate Pascale (Director, Kate Pascale and Associates).

## The EMR HACC GDCP project

Commencing in October 2011, the EMR HACC GDCP project sought to build the capacity of the local HACC sector for effective goal directed care planning by:

- Gaining a shared understanding of key elements of effective goal setting and care planning
- Providing opportunities to share knowledge, tools and expertise across the region
- Utilising a reflective practice approach to actively engage staff in the ongoing evaluation of their approaches, identify strengths and weaknesses and develop recommendations
- Undertaking a collaborative, regional approach to the application of the *Strengthening assessment and care planning: A guide for HACC assessment services in Victoria*, and other relevant care planning resources
- Developing recommendations regarding appropriate tools/templates to support effective, goal directed care planning.

A total of 56 staff, representing 39 local agencies participated in the project. This included representatives from a range of service types including:

- Local Councils
- Community health services
- Community based nursing
- Planned activity groups
- Social support and respite
- Case management
- Aged Care Assessment Services (ACAS)
- Direct 2 Care

Goal setting and care planning was identified as a fundamental component of all of the participants' roles. The project therefore provided the opportunity to share an enormous amount of expertise and experience across the sector. *Please refer to Appendix 1 for an overview of the key project activities*.

1 The EMR HACC Alliance is a local network that was created in 2010 (originally named the EMR ASM Alliance) to support HACC funded organisations in the EMR work collaboratively, share information, resources and ideas to support the implementation of the Active Service Model (ASM). It has subsequently been expanded to support broader quality improvement across the EMR HACC sector. The Alliance is supported by the Department of Health, EMR Regional Office. Further information about the Alliance is available at: http://www.iepcp.org.au/active-service-model-emr-hacc-alliance and http://www.oehcsa.org.au/special-project.

## Key project findings

The project reinforced the importance of GDCP in HACC services and identified a number of key areas for improvement.

### What clients and carers told us

While there was a plethora of evidence available discussing the importance of GDCP from a professional's perspective, very little evidence was found that identified client's attitudes. The project therefore collected valuable evidence about client's perceptions of goal setting and care planning. Of the 72 clients and carers surveyed:

- 86% identified that being asked what they wanted to achieve with our services was important (39%) or very important (47%)
- 79% reported they would like to set their goals together with staff (as compared to 18% who felt they could independently identify their goals and 3% who thought staff should set the goals)
- The type of goals they wanted to set were fairly evenly split between:
  - Goals about what I hope to achieve with this service (32%)
  - Goals that I want to achieve by working with this, and other health services (38%)
  - How my work with this service can help me achieve my general life goals (42%)
- 82% wanted written information about their care plan (most commonly the agreed actions and goals, staff contact details, and information about other available services)
- 86% reported they would use their care plan if they were given a copy. The most common uses identified were:
  - As a reminder about actions being taken (55%)
  - To talk to my family and/or carers about my work with this service (48%)
  - To keep track of my progress (45%)
  - To share with other health professionals involved in my care (38%).

### Opportunities for practice improvement

While staff reported a strong commitment to delivering person centred care and recognised the importance of GDCP, a number of practical challenges were identified. These included:

- Ongoing confusion between goals and actions
- Difficulties demonstrating the links between documented goals and actions
- Minimal engagement of family, carers or other staff/services in the development of the care plan
- Lack of appropriate referrals or collaboration with other staff/agencies
- Challenges developing goals and relevant actions for clients who have cognitive, intellectual or communication difficulties, lack insight or motivation, or are palliative
- Agencies currently use a wide range of GDCP templates – many of which do not support good practice
- Less than 50% of participants reported that their organisation has documented policies and/or procedures regarding goal setting or care planning (existing policies do not always support best practice)
- Inconsistencies regarding how client care plans are audited and evaluated.

Given these challenges, the project identified training and resource development as the priorities. In particular, participants sought training that focussed on practical strategies to build staff's skill, knowledge and confidence to develop and document appropriate goals and care plans with their clients. This toolkit is designed to build on that practical training and provide HACC staff with a range of resources to support good practice.

The complete project report and other relevant project information is available at: http://www.iepcp.org.au/active-service-model-emr-hacc-alliance and http://www.oehcsa.org.au/special-project.

# The EMR HACC Goal Directed Care Planning toolkit

The toolkit includes a range of practical tools to support staff set goals and develop effective care plans for HACC clients. It also includes information and guidelines to support organisations review their systems that support GDCP and evaluate their practice. The toolkit includes the following 5 chapters:

## Chapter 1: Goal Directed Care Planning as a key component of person centred care

Provides a brief overview of the importance of person centred care and advice about how GDCP, along with other key approaches, can be embedded into HACC service delivery.

## Chapter 2: A different conversation

This chapter focuses on the practical strategies that HACC staff can use to understand their client's strengths and priorities and how to use this information to identify relevant goals and care plans. The tools have been collated from a range of sources, and adapted to ensure their relevance for HACC services.

## Chapter 3: Documenting Goal Directed Care Plans

Includes guidelines about the key components of effective GDCP documentation and tools that support good practice. An example of an effective GDCP template has been developed, along with an audit tool to support agencies evaluate and improve existing tools.

## Chapter 4: Organisational systems that support effective Goal Directed Care Planning

Aimed at program leaders and managers, this chapter provides an overview of the organisational systems (such as policies and procedures) that support staff to embed a best practice approach. It includes a checklist that organisations can work through, which will assist you to identify and prioritise areas for ongoing improvement.

## Chapter 5: Evaluating your approach

A framework has been developed that can support HACC agencies evaluate and monitor their GDCP approaches. This includes strategies to evaluate current practice, collect feedback from staff, clients and carers and the organisational systems. Guidelines are included about how to embed a continuous quality improvement approach in practice – including activities that are relevant for practice staff and management.

## How to use the GDCP toolkit

The toolkit has been developed as a resource to support good GDCP practice in HACC services. The availability of the toolkit does not negate the need for training. Both for practice staff and for managers, we encourage the use of this toolkit along with practical, skills based training. The toolkit can then be used as a resource that staff can 'dip into' and use as a workbook to assess current practice, prioritise and implement changes to build the capacity of staff to implement quality GDCP in the context of their organisation. Included are a range of activities and suggestions about how each of the tools can be introduced and applied in your services.

In practice, it is essential to acknowledge however, that formal goal setting processes are not relevant, or appropriate for all clients, nor is there a 'one size fits all approach' that will allow you to set the right goals with all clients. This toolkit is designed to provide HACC staff with a range of ideas and new approaches – it is not expected that they will be used for every client. Staff need to use their experience and professional judgement to identify if, when and how, each of these tools is applied.

# Chapter 1: Goal Directed Care Planning, a core component of Person Centred Care

This chapter provides a brief overview of the importance of person centred care and advice about how GDCP, along with other key approaches, can be embedded into HACC service delivery.

Over the last decade, there has been a significant shift in public health policy, towards person centred, strength based approaches to care. Health and community service sectors are increasingly adopting a more holistic, enabling approach that recognises the importance of empowering individuals to make choices and be actively involved in making decisions about the care they receive.

## The principles of person centred care

Grounded in a social model of health, person centred approaches are underpinned by the following key principles:

- Every individual is the best expert in their own lives. Clients should be actively involved in setting their own priorities and making decisions about how they want to be supported with their health
- Services should build on a client's strengths and capabilities and adopt a 'doing with, not doing for' approach
- Services need to be flexible and ensure services are delivered in a way that reflects each client's values and priorities. This includes tailoring supports to match the client's needs by:
  - Empowering clients with information and strategies they can adopt to promote their health and wellbeing
  - Facilitating access to other relevant supports (formal and informal)
  - Providing individual and/or group services
- Effective care planning requires a collaborative approach, in which staff work together with the client, carers and other service providers, to deliver a holistic and individualised response
- Staff need to be empowered to utilise their expertise and professional judgement to design flexible and appropriate solutions and tailor service delivery to meet the client's unique needs.

## Person Centred approaches in the Victorian HACC sector

In the Victorian Home And Community Care (HACC) sector, this approach is now embedded throughout the sector's program guidelines, quality framework and accreditation systems. This includes:

- Victorian HACC Program Manual
- The Active Service Model
- Diversity Planning and Practice
- The HACC Assessment Framework
- Strengthening assessment and care planning: A guide for HACC assessment services in Victoria
- Community Care Common Standards (CCCS) and the Victorian HACC Quality Review Resource
- Victorian Service Coordination Practice Manual
- The Australian Charter of Healthcare Rights.

For many HACC agencies, this has required a re-orientation of the way services are planned and delivered and is therefore an ongoing change management process. Similar work is happening in many Australian states and this aligns with international work across health and community service sectors.

## The benefits of a person centred approach

There is strong evidence about the benefits of this approach for clients, staff and service providers. These include:

- Empowering clients to make decisions about their care
- Building clients' confidence and a sense of ownership over their care
- Developing effective, appropriate and responsive care plans
- Facilitating client commitment and buy-in to actively participate in improving their health
- Increasing client and staff satisfaction
- Supporting effective service coordination, information sharing and collaboration
- Reducing duplication and enhancing continuity of care.

## Where does Goal Directed Care Planning fit?

For the purpose of this toolkit, Goal Directed Care Planning (GDCP) is defined as:

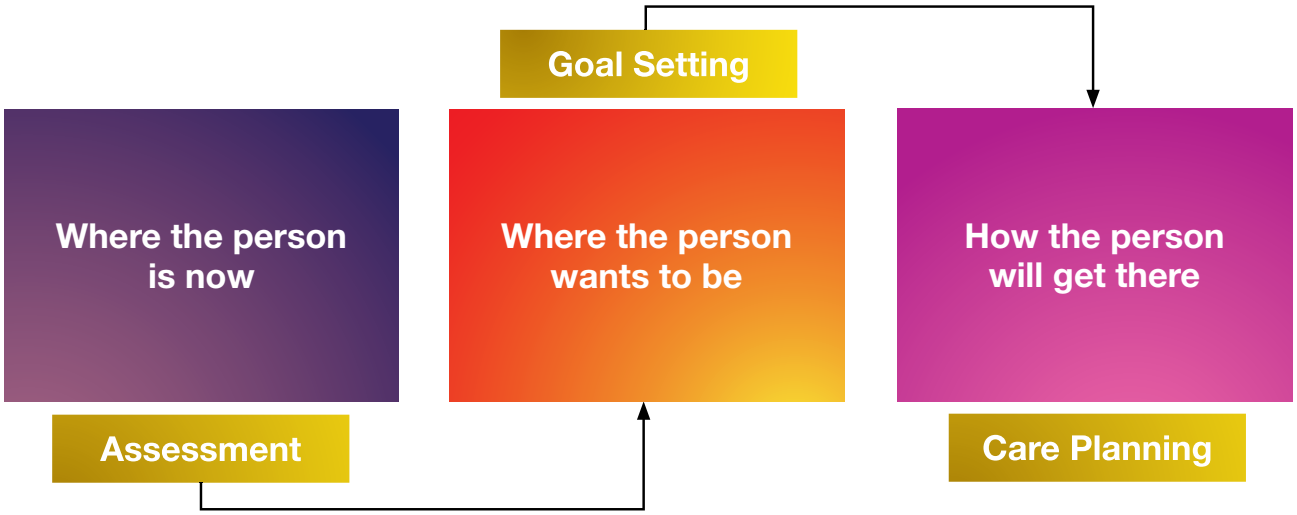
> *'The ongoing process through which staff and clients work together, to collaboratively set goals, establish priorities and develop strategies to achieve positive and meaningful outcomes for clients'.*

Throughout the best practice literature, GDCP is acknowledged as a fundamental component of a person centred approach. It places the client at the centre of their care and encourages staff to work in partnership with the client, their family, carers and other service providers to deliver care in a way that is responsive to their individual needs and priorities. GDCP has the following core components:

- Collaboration between the person and family or carer
- Setting goals that are meaningful and important to the person and their family or carer
- Identification of service options, interventions, referrals and connections
- Identification of the steps to reach the person's goals
- A timeline with start and end points, including review processes along the way
- A potential to work with other agencies through shared care planning.

Based on this evidence, the Victorian HACC program manual and Community Care Common Standards (CCCS) stipulate that **all HACC services should be working towards embedding GDCP as a core component of care**. Whether completing a service specific assessment, or a more comprehensive assessment (such as a Living At Home Assessment), goal setting is identified as the link between assessment and care planning and is broadly applicable in all settings.

**Figure 1: Goal setting as the interface between assessment and care planning.** Diagram reproduced with permission from the Strengthening assessment and care planning guide (DH 2010).




## Embedding a person centred approach throughout the client journey

Goal Directed Care Planning (GDCP) is one of many ways to apply a person centred approach. To maximise its effectiveness, it needs to be applied in the context of a holistic, coordinated and collaborative approach to care. The Victorian Service Coordination framework is a key strategy that supports effective, person centred care across all health and community service sectors. The Victorian Service Coordination Practice Manual outlines key components of this approach throughout the client's engagement with the service system. Included in the table below, is a brief overview of some of these strategies.

It is essential to note however, that this is rarely a linear journey and needs identification, assessment and care planning are, in fact, ongoing processes that continue throughout the client's episode of care.

***Note:*** *Additional information about each of the tools and strategies listed below is provided in subsequent chapters*

### Remember: Information is only useful when it is used and shared!

- Ensure the client is supported to choose who they want involved in planning, decision making and their care
- Ask for consent to share the information appropriately and document consent according to your organisation's privacy and consent policy
- Ensure information is recorded and used to inform and monitor ongoing care.

## Embedding a person centred approach throughout the client journey

| Care Phase | What you're trying to achieve | Strategies to support effective GDCP and a person centred approach |
|---|---|---|
| Initial Contact | Identify opportunities for information sharing and collaboration (reduce duplication for staff and clients, increased efficiency) | Provide accurate information about your service, eligibility criteria and your approach<br><br>Ask the client who they would like to have involved in their assessment / care planning and decision making processes (be sure to gain consent to share relevant information)<br><br>Identify who else is / has been, involved and collect relevant handover information PRIOR to initial assessment wherever possible (given client consent)<br><br>Offer a clear action plan and concrete next steps (e.g. 'an intake worker will call you on Friday to gather more information and ensure we're the right service for you' OR 'the next step is to make a time to come out to your home and conduct a detailed assessment and understand how we can best support you') |
| Initial Needs Identification | Get a broad understanding of the client's situation and needs<br><br>Identify who needs to be involved to support the client (within and beyond your service) | Ask broad questions about the current situation and what the client is hoping to achieve<br><br>Do not limit your discussion to the services offered by your program / service or the presenting issue<br><br>Remember that just because you identify a need, doesn't mean that you are solely responsible for providing the solution |
| Assessment | Gather further information about the person's needs and circumstances and understand what is important to them | Gather a rich history and explore the current situation in order to establish a baseline (utilising information collected within previous assessments wherever possible to reduce duplication)<br><br>Consider a range of factors that impact on the client's function, attitude and goals (e.g. psychological, biological, social and environmental factors)<br><br>Identify the client's existing support structure *(tool: relationship circle)*<br><br>Focus on listening and understanding what is happening for the client, what is important to them and what is required to ensure their health, safety and wellbeing *(tool: important to/ important for, good days/bad days)* |

## Embedding a person centred approach throughout the client journey (cont.)

| Care Phase | What you're trying to achieve | Strategies to support effective GDCP and a person centred approach |
|---|---|---|
| Goal Setting | Collaboratively identify and prioritise the client's goals. This may include goals that relate specifically to their engagement with your service, their health care and/or broader life goals | Understand the client's needs and priorities *(tools: important to / important for, the five whys)*<br><br>Identify the client's strengths, capabilities, existing supports and potential barriers to care *(tools: what's working / what's not working, good days / bad days)*<br><br>When relevant, work together to develop and document SMART goals *(see Developing appropriate goals)* |
| Care Planning | Work together to develop and document strategies to support the client achieve their goals, prioritising needs and actions to optimise outcomes<br><br>Rather than focussing on what services / support the organisation can provide, GDCP requires agencies to focus on what supports the person needs to achieve their goals. Therefore the support is individualised and considers formal and informal supports as well as what the client will do to achieve their goal. | Investigate strategies that the client has already utilised to address their concerns / challenges *(tool: 4 + 1 questions)*<br><br>Encourage the client to identify appropriate solutions and share responsibility for their care *(tools: My best support, Exploring Options)*<br><br>Include relevant people in the development of the care plan and clarify roles and accountability<br><br>Discuss and document how you will identify whether the action is complete and consider its impact on the relevant goal/s<br><br>Ensure that the links between goals and actions are clearly articulated<br><br>Prioritise actions based on urgent and fundamental needs<br><br>Document the care plan using appropriate and accessible language *(tool: GDCP template)*<br><br>Share appropriate information with others (client, carers, staff and other service providers) given client consent<br><br>Your care plan should evolve over time and remain a living document that reflect the client's changing needs and priorities (ongoing monitoring and review is essential) |

## Embedding a person centred approach throughout the client journey (cont.)

| Care Phase | What you're trying to achieve | Strategies to support effective GDCP and a person centred approach |
|---|---|---|
| Service Delivery<br><br>(Intervention/ Treatment) | Implement client's care plan | Actively engage the client and their carer/s in the delivery of care<br><br>Provide information that is relevant and accessible (consider when and how information is delivered)<br><br>Be thoughtful about how and when care is delivered and who is involved. Where possible, look for opportunities to match clients with the right support team *(tools: matching tool)* |
| Monitoring & Review +/- Reassessment | Ongoing evaluation of the client's needs and their care plan<br><br>Identify and respond to changing needs and priorities | Actively seek formal and informal feedback from the client, family, carers, staff and other service providers to ensure:<br>• the care plan is being implemented as agreed<br>• the client, carer/s and relevant staff are satisfied with the actions being taken<br>• issues and barriers are identified and resolved quickly and effectively<br><br>*(tools, what's working / what's not working, 4 + 1 questions)*<br><br>Conduct periodic reviews, ensuring that relevant people are encouraged to participate<br><br>Establish clear 'flags' for re-assessment based on functional, environmental and/or situational changes |
| Transition & Exit/Discharge Planning | Support the client to modify or exit from your service safely and effectively<br><br>Link the client to alternative supports | Start Early! Discuss your agency's discharge processes throughout their episode of care to ensure you create clear expectations<br><br>Maintain an open conversation with the client and support them to make choices about ongoing care |
| Referral | Support the client to access appropriate information, support and services in a timely manner | Referrals can occur at any point in the client's care and are essential to promote continuity of care<br><br>Consider the handover information that you can provide to (and collect from) other services in order to facilitate the client's transition, reduce duplication and support shared care planning<br><br>Note: Victorian HACC agencies are encouraged to use the Victorian SCTT referral templates to support consistent information sharing and referrals |

# Chapter 2: A different conversation

This chapter focuses on the practical strategies that HACC staff can use to understand their client's strengths and priorities and how to use this information to identify relevant goals and care plans. The tools have been collated from a range of sources, and adapted to ensure their relevance for HACC services. Additional information and guidelines are provided in Strengthening assessment and care planning: A guide for HACC assessment services in Victoria.

Effective GDCP is reliant on staff's skill and confidence in having a conversation with the client (and their carer/s), understanding their needs, priorities and identifying how best to support them to achieve their goals. This is often embedded into the assessment process, but can also be completed as a stand-alone activity. A person centred approach to assessment requires us to move away from a 'tick the box' style assessment and adopt a more conversational, in depth approach. This requires staff to:

- Take time to build rapport with the client (and their carer/s)
- Adopt a strengths based approach – focussing on the client's abilities, resources and interests, in order to tailor your services to meet their individual needs. This is likely to increase their ability and motivation to engage in an activity
- Demonstrate a commitment to genuinely understand the person's values, priorities and needs (e.g. through active listening, observation and conversational prompts)
- Consider the person's needs within and beyond the scope of services that your agency offers
- Empower and support the client to make informed decisions about their care.

This chapter includes a range of tools that are designed to support staff during their conversations with clients.[2] They can assist you to:

- Gather information about the client, identify their strengths, concerns and priorities for change
- Clarify presenting issues
- Increase the client's involvement and promote a partnership approach to goal setting and care planning
- Design holistic and responsive care
- Reflect on and monitor service delivery.

It is acknowledged however, that formal goal setting processes are not relevant, or appropriate for all clients, nor is there a 'one size fits all approach' that will allow you to set the right goals with all clients. This toolkit, is designed to provide HACC staff with a range of ideas and new approaches – it is not expected that they will be used for every client. **Staff need to use their experience and professional judgement to identify if, when and how, each of these tools are applied**.

> Regardless of the approach, it is essential that all clients are asked about what they want to achieve from a service and how they want services to be delivered.

*The approaches and tools provided in this chapter include person centred concepts, principles and materials used with permission from the The Learning Community for Person Centred Practices and Helen Sanderson Associates.*

2 Basic templates, for each of the tools are also available in Microsoft Word format at http://www.iepcp.org.au/active-service-model-emr-hacc-alliance and http://www.oehcsa.org.au/special-project. Staff are encouraged to adapt and modify these templates for use in your own service.

## Introducing the tools

Before trialling these approaches with clients, it's essential to familiarise yourself with the tools so that you develop a good understanding of when and how these may be useful in your practice. While we strongly advocate for staff to attend relevant training, included below are some suggestions about how you can introduce the tools within your own agency.

1. Read through the information provided and look at the case studies included throughout this chapter
2. Choose one or two tools that you think will be particularly relevant (you can then gradually add more tools as your skill and confidence increases)
3. Set aside time in a team meeting to discuss the tools – Brainstorm when and how this tool could be useful with your clients
4. Practice using the tools with other staff.
   - What did you find out about your own goals?
   - Has anything changed about the way you see this issue?
   - It's important to use real examples (it doesn't matter what area of your life the discussion relates to e.g. work, family, leisure or health issues)
5. Consider when you could introduce the tool to clients
   - Would it be helpful to send the tool out prior to meeting the client? This gives clients time to work through it before you meet and that information is then used as the basis of your discussion
   - Is it something you could embed into your initial conversation / assessment?
   - Could you complete the tool as part of a group or one-on-one activity?
6. Begin using the tool/s, (as appropriate) with clients
7. Come back together and reflect on your experiences of using the tools (you could use the working/not *working tool, or 4 + 1 Questions to support this*)
   - What worked really well?
   - Did the tool help you get the information you were looking for?
   - What would you do differently next time?
8. Continue using the tools and ensure that you have ongoing opportunities to review your progress, reflect on your achievements and identify what additional support or information you may need to make the most of these approaches.

## Developing appropriate goals

Goal setting provides you with a clear focus about the way you will work with the client. A clients goal shows you the destination, you can work together to design the roadmap that you will use to get there. Evidence demonstrates that setting goals that align with the client's values and priorities, encourages them to take responsibility and commit to making the changes necessary to improve their health and wellbeing.

### Goals should describe what the client / carer hopes to achieve

- Goals should be written as positive, action oriented statements (e.g. I want to join, develop, complete, achieve, learn …)
- Wherever possible, SMART goals should be documented
- While clients should have ownership of their goals, goals do not always have to be written in the client's words. It is often helpful to work with the client to explore their goals and agree on wording that clarifies ambiguities and includes the appropriate level of detail
- Many staff report that the word 'goal' is not meaningful for their clients. Consider using alternative language both in conversation, and on your documentation (e.g. a question about 'what the client hopes to achieve') rather than just using the heading / prompt 'goals'
- When a client identifies multiple goals, it can be useful to prioritise them. Be realistic about what can be achieved! When clients are hoping to achieve significant change, or require a large number of referrals or interventions, work together to prioritise the actions and set achievable timeframes.


Often, clients will identify very broad goals. To support you to develop an appropriate care plan, it's important to work with the person to break those goals down into measurable steps by asking probing questions.

When asked about his goals, John reports: I want to feel happy

In order to find the right supports for John, we need to ask further questions

- What would it look like if you were happy?
- What has made you feel happy in the past?
- What are some things that you would be doing if you were happy?

This information will enable you to break John's large goal, into some more specific SMART goals that you can then include on your care plan. These goals may include:

- I want to join a regular activity group where I can spend time with a group of people my own age
- I want to improve my fitness so that I can feel healthy and strong

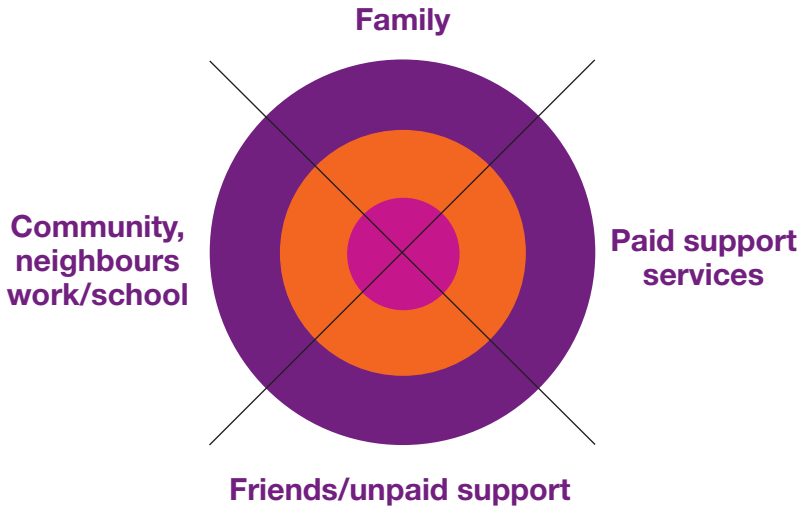
# Relationship Circle[3]

## What it is:

- A relationship circle provides an alternative way to talk about who is involved in a person's life and the different roles those people play
- It provides a visual description of a person's support network and the nature of key relationships
- It helps you to quickly identify when someone may be socially isolated, heavily dependent on one person / paid supports etc.
- It removes the traditional bias towards family being the primary support (i.e.: a client may not have any family, but still have created a strong support network, while a person with a large family and/or live-in carers may feel isolated and alone).

## How to use it:

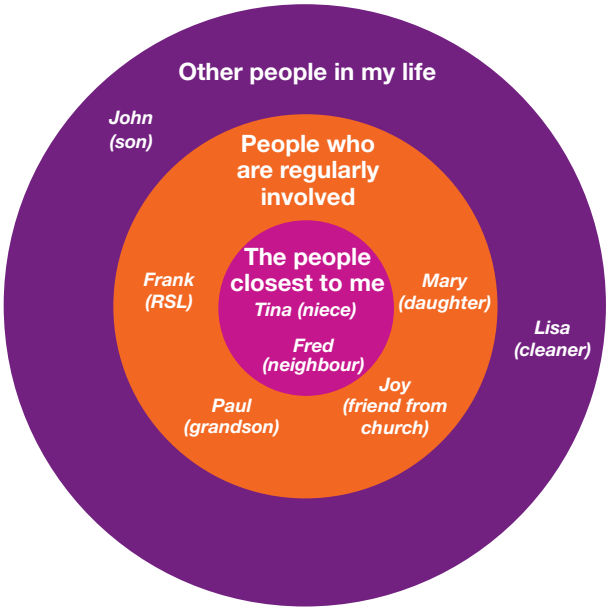
- There are no specific rules or guidelines about how to allocate people into each circle. It is a subjective exercise that encourages the client to use their own rationale to assign people into the various circles. The inner circle should include people who are closest to the person. These will be the person's most important relationships.
- Adding quadrants (as seen in the second example below) can be useful to prompt people to think about a range of different supports. You can however, use any relevant labels or sections.
- Be as specific as possible – it is useful to include names rather than simply writing general roles (e.g. home help staff).
- You can also use the relationship circle to talk about who the client would like to include in decision making and who you should communicate with about their care.
- The circle can be created during your assessment, or provided to the client beforehand so that they have time to complete it prior to your appointment. Either way, the circle should be used as the starting point for a conversation about key relationships and available supports.


3 The *relationship circle* information included in this toolkit has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/

## A relationship circle in action:

**Assessor:** Using this circle, can you tell me about the important people in your life? In the blue centre circle, we'll put the people who are closest to you and then we'll work our way out, to include the other people you have around you. We can include anyone who plays an important part in your life – family, friends, neighbours, paid services or perhaps people from any community groups you belong to. Think about who is closest to you emotionally, rather than physical closeness or how regularly you see people.




## What we learned:

This open questioning has quickly identified that the client has a range of supports available – many of which sit outside her immediate family. The conversation held between the assessor and the client would then elicit further information about the nature of these relationships.

## What HACC staff said about using the Relationship circle:

- This was a simple and easy way to find out about who was involved and who was important in the client's life
- It gave me a great overview of the situation and helped me identify the gaps in their support system. We were then able to have a conversation about how we could help fill those gaps
- This gave me a different way to ask questions, that was more client led, to about who supported her.
- The circle highlighted the client's dependence on specific people in her family that she hadn't acknowledged before. This raised her own awareness of the issue and we were able to discuss strategies to support her and her family
- It allowed me the opportunity to talk about the importance of support networks for all of us, whether it be family, friends or organisations they access

# Important to vs. Important For[4]

## What it is:

A strategy to sort what matters to the client versus what matters to others, and to find the balance in between:

- It reinforces a holistic approach and validates the importance of happiness and wellbeing as a component of health
- It provides the opportunity for the client to reflect on the things that really matter to them. People are more likely to be motivated about setting and following goals if they connect to things that are important to them
- Assists you to develop a care plan that is based on what is important to the client and focusses on them as a person (rather than just a patient / client)
- Also useful when the client's priorities and expectations are different from others around them (allows you to look at different perspectives and give people a voice).

## How to use it:

- Ask the client (and their family / carers) to think about what's important to them (what makes them tick) and then look at what is required to ensure they are healthy and safe
- Use information that you have gathered throughout your conversation, listening for themes about what is important to people and use this to guide your conversation
- Try and be as specific as possible – find out about the specific elements of the role, activity or issue that are important
- Aim for balance (we need to remain safe, but also recognise that it's important to do things that make us happy)
- There is no right or wrong – if it matters to the client, it belongs on the list! The client should decide what is important to them. If it matters to others, rather than the person, it belongs in important for
- Can be used during an initial assessment or as part on a monitoring or review process.

4 The information included in this toolkit regarding *Important to vs. Important for* has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/

## Important to vs. Important For in action

| **What's important to me?**<br>What makes me happy / content / fulfilled and improves my sense of wellbeing? | **What's important for me?**<br>What do I need to keep me healthy and safe? |
|---|---|
| *Talking to my friends and family every day* | *Taking my medications on time each day* |
| *Being helpful to others:*<br>• *Knitting for the Children's hospital*<br>• *Baking for my church's Sunday school group* | *Eating well* |
| *Having a beautiful garden to look at* | *Keeping my joints moving so they don't get stiff and sore* |
| *Watching the news and keeping up with what's happening in the world* | *Maintaining my house and garden so that I won't trip over* |

## What we learned:

Joan has identified a number of things that are useful starting points for the conversation about her care plan. We could also ask Joan's key support people what they think is important and look at how they relate to the issues that Joan has identified.

### What HACC staff said about using Important to vs. Important for:

- My client had limited communication skills and this was the easiest way to find about his goals. It was simple and easy language and he could answer in a few words
- It gave the client an opportunity to express what was important to her, rather than having others tell her what she needed to do
- It was very helpful. It was good for the client to put words to their thoughts and actually think about the positives. It gave her direction, motivation and optimism!
- This kept the focus on the client as a person with interests, needs and ways of coping in the midst of complex requirements. It helped to broaden the picture as it identifies interests and likes which were not currently being met, as well as those that the client was maintaining at all costs
- It was easy to integrate into our conversation – you don't necessarily need to write the formal list – so it felt comfortable and easy.

# The Five Whys[5]

## What it is:

- The Five Why's is a problem solving technique that encourages us to think about the underlying causes of an issue
- It is often very tempting to jump straight to finding solutions, but this can lead us to work on a 'symptom' of the problem, without understanding the issues that sit beneath it. Therefore, the five whys encourages us to continue asking questions in order to explore the situation until we have a deeper understanding of what's happening.

## How to use it:

- Useful when a client identifies an action rather than a goal and when the client's requests / expectations may not reflect the situation or address the whole issue
- Be flexible and creative about the questions you ask (the important part is that you ask open ended questions that encourage the client to reflect and explore what is important to them)
- Be thoughtful about the questions you ask as you don't want to 'interrogate' the client. It is useful to practice using this approach with your peers and other staff first to build your confidence and identify a range of useful questions
- When introducing this to a client, be clear that this is a coaching technique and explain your rationale for this approach. If the client identifies this as useful, proceed with questions, remaining thoughtful of your own skill and expertise and the need to engage others to address any issues that arise.


5 *The Five Whys* technique was originally developed by Sakichi Toyoda of the Toyota Motor Corporation. The information included in this toolkit has been adapted from: Tri- Counties Regional Center & Helen Sanderson Associates (2008) *Person Centred Thinking Coaching Cards: A series of cards for people who help other in their mastery of person centred practices*, HSA Press, UK available at http://www.hsapress.co.uk/publications/infocards.aspx

## The Five Whys in action:

| Joan has mentioned that she's interested in attending a day program… | |
|---|---|
| **WHY** are you interested in a day program? | *Because I don't go out anymore and I feel lonely at home all the time* |
| **WHY** don't you go out anymore? | *Because my husband died recently and he always drove me to my activities at church* |
| **WHY** have you decided not to go to church alone or with a friend? | *Because I don't like driving and I don't want to burden my friends with having to pick me up all the time* |
| **WHY** do you think a day program would be a good option for you? | *Because I get nervous going out alone and my daughter told me they have a bus that comes and picks everyone up* |
| **WHY** do you not want to catch the community bus that runs to church? | *Because everything at church reminds me of my husband and it makes me sad to go there alone* |

## What we learned:

By asking these questions, we have uncovered a number of underlying issues that are affecting Joan's community engagement. We have identified that a range of additional / alternative supports may be required to support Joan achieve her goals.

## What HACC staff said about using The Five Whys:

- My client thought she had the solution to her problem, but I wanted to explore with her the real issues. It helped her think deeper about her issues and assisted with identifying realistic strategies to solve her problem
- Initially, it seemed that the client thought she should go to exercise class, but there seemed to be something 'blocking it', this tool kept me drilling down until we understood what was sitting underneath it all
- It's important to present this in a sensitive and supportive manner to ensure the client feels comfortable about being asked so many questions.

It can be hard to think of the right 'why' questions – it's important to practice this tool so you can feel more confident about finding the right probing questions

# What's Working / What's Not Working[6]

## What it is:

- This is a simple and effective way to look at the positive and negative aspects of a situation in order to identify what to build on (what's working) and/or what needs to change (what's not working)
- It can be used to explore a specific issue (e.g. how well do you feel you are managing your diabetes at the moment?), or as a general overview of what's happening for a person (e.g. what's happening in your life now?)
- It supports people to break the situation down and identify specific issues / strategies / approaches that they feel are effective and / or ineffective.
- It encourages honest and open feedback from the relevant people in a non-threatening way.

| What's Working | What's Not Working |
|---|---|
| | |
| | |
| | |
| | |

## How to use it:

- Draw up a simple table and work with the client to make a list of what is and isn't working for them in their life right now. Encourage the client to break down broad issues so that you have specific answers to work through
- Once you've identified 'what's working', you can look at ways to build on those aspects of the person's life (and ensure they are not lost)
- It can be used as part of your needs identification, assessment or during a review
- By adding an extra column to the left side of the table, you can also use this tool to explore an issue from multiple people's perspectives – this helps people to identify and then effectively work through issues of conflict or disagreement.

6 The information included in this toolkit regarding *What's Working / What's not Working* has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/

## What's Working / What's Not working in action:

**Assessor:** Now that you're living home alone, what is working well and what is not working for you?

| What's Working | What's Not Working |
|---|---|
| My niece calls me every morning so that she knows I'm safe. That makes me feel more confident | It's hard to think of meals that I can cook every day. I don't want to make a big effort just for myself, so often I just have toast and a cup of tea for dinner |
| My neighbour Fred is home during the day, so I know there is always someone nearby if I get stuck | The garden is really overgrown because my arthritis makes it difficult to kneel down and I can't use the secateurs anymore |
| I get tired quickly, so I break up my chores and just do a little bit at a time | I don't go out much anymore because I feel nervous driving. I get a bit lonely at home alone sometimes |

## What we learned?

Joan is encouraged to consider the issues herself and pin point those that are most relevant to her. She has identified a number of issues that can then be used to inform the development of her care plan.

### What HACC staff said about using What's Working / What's Not Working:

- This client's situation is changing rapidly, so it was a useful way to allow her to express her needs and to create a clear picture of what she is managing
- It prompted the client to recognise what she is capable of and helped her husband recognise where he can be more independent
- The client was very stressed and anxious. This provides a focus for the assessment, focussed on some strengths and helped us work out the key issues
- It put the client in the driver's seat and helped them review the situation so they could make decisions and start to take positive actions
- This just sums it up so well! It's simple and easy and allows the client to give feedback in safe and supported way

## What's Working / What's Not Working in action:

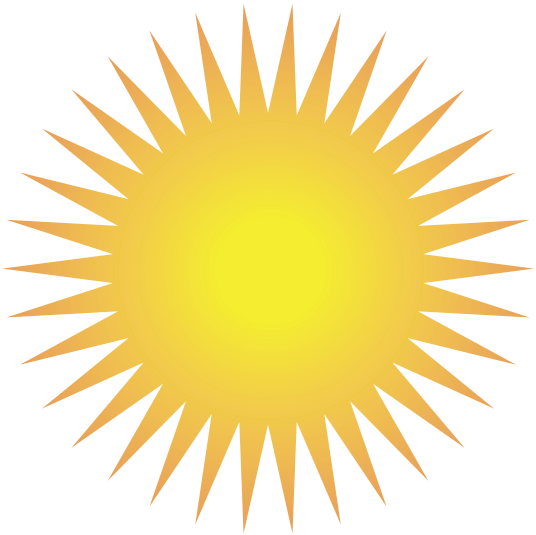
**Assessor:** It's been 6 months since we first met and organised some additional services for you. How do you think the services are going? Can we make a list of what you think is, and is not working for each of you?

| Perspectives | What's Working | What's Not Working |
|---|---|---|
| Joan (client) | It's great having Lisa come every week. My joints are less painful now that I don't have to get down on my hands and knees to clean the shower. Lisa always stays and has a cup of tea with me after she's finished cleaning | Lisa always puts on a load of washing for me, but it's too heavy for me to lift out of the machine. I think it would be better if I put the washing on and then Lisa could help me hang it out |
| Tina (niece) | I feel more confident that Auntie Joan is eating properly now that meals on wheels are being delivered 3 days a week. | Mary and I bring dinner over on Wednesdays and Fridays and we always leave enough leftovers for Joan's lunch the next day, so we would prefer to swap the days for delivered meals |
| Mary (daughter) | Mum seems much brighter now that she is having more regular contact with people and she really enjoys seeing everyone | I have changed my days of work so I can take Mum to the shops now on a Friday, but she won't let me because she's worried about upsetting Lisa's schedule |
| Lisa (home carer) | Joan is well organised and likes to get involved, so we clean the house together. | When we go to the shops, Joan is having trouble counting the money and often asks for help to pay the cashier |

## What we learned?

This has provided a useful overview of the effectiveness of the existing care plan, including feedback from the key people involved. By proactively seeking constructive criticism, we've been able to identify tangible benefits, specific achievements and areas for improvement. Moving forward, we can continue to refine the way services are provided (e.g. Lisa to begin hanging out the washing, change meal delivery schedule), talk to Joan about how she would like to proceed with her shopping and explore the challenges that Joan is having handling money in order to identify an appropriate solution.

# Good Days and Bad Days[7]



## What it is:

- A simple tool to encourage discussion about what specific aspects of a situation or lifestyle are beneficial and need to be supported, as well as those that are challenging or difficult (and need to be removed, avoided or re-worked)
- Helps us to learn about what is important to the person and how best to support them in different circumstances
- Identifies triggers for stress, anxiety or disappointment
- Useful to orient discussions with family and carers to ensure that everyone understands the clients priorities and how we can provide support in appropriate ways.

## How to use it:

- Divide a page into two columns (good days / bad days) and ask the client what makes a day good or bad for them
- Be flexible about how you complete the table – you can work through times of the day and look at both good and bad aspects of certain times / routines (when you wake up, what makes your day start well / badly), or you can work through what a good day looks like first and then talk about what would make a day bad
- Once you've made the list, be sure to ask:
  - What needs to happen to have more good days and less bad days?
  - Are there things others could do to support you on bad days?
  - Are there things on your bad day list that need to change?
  - Are these things that you could add that would make a good day even better?

7 The information included in this toolkit regarding *Good days and Bad Days* has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/

## Good Days / Bad Days in action:

| I have a good day when …  | I have a bad day when …  |
|---|---|
| I wake up and my knees don't ache<br>My niece rings me in the morning<br>People turn up on time<br>I go out and talk to people<br>I have a laugh with my friends | The carers arrive too early and I haven't had my breakfast<br>The bus is late<br>I spend the whole day alone<br>My joints are too sore for me to go for a walk |

## What we learned?

Joan has identified a number of specific issues that impact on her wellbeing and happiness.

These provide solid ideas about where to start with her care plan and the key messages we can provide to staff about when to schedule visits and how to provide optimal support.

### What HACC staff said about using Good Days & Bad Days:

- The client appeared to be a 'glass half empty' person, this really opened up the conversation among the client, the son and myself
- It was a very complex situation and this tool helped us to reflect on the fact that there were some positives in his life
- This tool gave us all a clear focus on the person and reinforces that we were there to seek ways to best meet their needs
- This is a great approach for clients with dementia – the language is simple and the structure and format is very clear and easy to explain / understand

# 4 + 1 Questions[8]

## What it is:

- A structured way to look at a situation, reflect on where you're up to and then explore options to move forward
- Directs you to look at the positives of past efforts, what has worked, what has been learnt so far and what you can build on and change in the future.

## How to use it:

- Run through each of the questions (in order) and note down the key issues
- Useful when reviewing a specific challenge or issues and especially when a client feels overwhelmed, like they've tried everything and/or have failed in the past.

| |
|---|
| What have we tried? |
| What have we learned? |
| What are we pleased about? |
| What are we concerned about? |
| Given what we know, what next? |

8 The information included in this toolkit regarding *4 + 1 Questions* has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/

## 4 + 1 Questions in action:

Joan has been attending a local walking group for the last 3 months but the pain in her knees has made it difficult to keep up with the other walkers

| | |
|---|---|
| ? What have we tried? | I've been going to the Senior Citizens walking group every Monday morning<br>My GP suggested taking panadol osteo half an hour before leaving home, but I'm too rushed in the morning and I sometimes forget. Even when I do take it, it doesn't reduce the pain |
| ? What have we learned? | I really enjoy the group because it's a great way to meet new people and we have a chat as we walk<br>An 8am start is too early for me |
| ? What are we pleased about? | I feel proud of myself for trying something new I like exercising in a group |
| ? What are we concerned about? | The ongoing pain in my knees<br>I can't keep up with the group and feel awful for slowing them down<br>I am so worried about waking up early that I don't get any sleep the night before and that makes my pain worse |
| ? Given what we know, what next? | I will organise another appointment with my GP to look at alternative pain relief<br>Kate will make a referral to the Physio at the Community Health Centre to assess my mobility and provide advice about other group exercise programs<br>I will ask my neighbour Fred, whether he would like to walk with me in the afternoons |

## What we learned?

This has encouraged Joan to reflect on her experiences, celebrate the success she has achieved so far and identify specific strategies to help her move forward.

### What HACC staff said about using 4 + 1 Questions:

- My client has a short attention span and gets side tracked easily so he can be quite challenging to work with. This was a simple, structured way to identify and explore options for moving forward
- It was really easy to generate goals and actions for the care plan based on the information we collected using this tool
- I already knew the client, so this was a useful way to initiate a conversation to review her needs and make a plan about how I could support her

# My Best Support[9]

## What it is:

- A simple tool that supports the client to communicate important information to their support team
- A strategy to discuss and describe risks and work together to make decisions about how to manage them
- It can be used to explore a range of issues including:
  - When and how care is delivered
  - Who should be involved in decision making
  - How to manage challenging situations or behaviours
  - How the client wants to participate in certain activities.

| To keep me healthy and safe | |
|---|---|
| **You need to know this:** | **And do this:** |
| | |

## How to use it:

- Ask the client (and carers) about what they'd like their carers / support team to know about them and how to best support them to stay healthy and safe
- Be flexible about the labels you use in the table
- Share the tool with staff, carers and others who will be involved in delivering care (with client consent).

9 The information included in this toolkit regarding *My Best Support* has been adapted from concepts, principles and materials used with permission from The Learning Community for Person Centred Practices: http://www.learningcommunity.us/ and Helen Sanderson Associates (2009) *Support Planning: tools to help you with your support plan*, HSA Press, UK available at http://www.hsapress.co.uk/publications/infocards.aspx

## My Best Support in action:

| To keep me healthy and safe | |
|---|---|
| **You need to know this:** | **And do this:** |
| I don't like being asked lots of questions – it makes me feel anxious. When I get nervous, I find it hard to make decisions | I like to follow a consistent routine and prefer a written plan<br>I make decisions best in the morning, when I feel refreshed<br>I would prefer to have my niece or daughter present when making important decisions about my care |
| I have epilepsy and need to take my medication 3 times a day. Sometimes I have seizures. When I'm about to have a seizure, I have ringing in my ears | Ensure I have enough medication for the week<br>When I say I have ringing in my ears, take me to a safe place to sit and protect my head with something soft |
| Looking after my dogs is very important to me. I want to walk them every day, but I get tired quickly and need regular breaks | Plan my activities so that I have enough energy to walk the dogs each day<br>At the beginning of every shift, ask me whether I would like to walk the dogs and make sure I have time to rest before and after the walk<br>While we're walking, encourage me to take short breaks every 5 minutes, so that I can catch my breath |

## What we learned:

This provides a snapshot about things that are important to Joan. It can be shared with other staff / support people, to avoid Joan having to repeat herself and provides clear advice about how to best work with Joan in the future.

## What HACC staff said about using My Best Support:

- It was a useful way to understand the client's preferences, enable them to make choices and identify really practical strategies about how to provide appropriate support
- It opened our discussion and led to insights about new ideas and goals that I had not anticipated
- My client spoke limited English, so this was an easy and clear way to guide our planning
- It helped provide a focus about what is needed to achieve her goals
- While I think it would be valuable in lots of settings, this fits really well for respite clients

# Exploring Options[10]

## Traditional Option

## Radical Option

## Different Option

### What it is:

- A fun way to actively engage the client to identify solutions
- It allows you to work together and encourages the client to think outside the square, recognising that there are a range of ways to achieve their goals.

### How to use it:

- Before you start exploring options, ask:
  - What do we have? (e.g. skills, resources, assets, supports)
  - What do we want to achieve?
- Then have fun with it, be creative and brainstorm a range of options
- Don't limit the solutions to the services your agency provides. Look at how you can engage other services, engage informal supports and build on the client's existing strengths and resources
- Talk about how you could implement these options, who should be involved and what supports are available to assist them
- You can implement any, or all of these ideas as part of your care plan.

10 The information included in this toolkit regarding *Exploring Options* has been adapted from concepts, principles and materials used with permission from Helen Sanderson Associates (http://www.helensandersonassociates.co.uk), in particular, Helen Sanderson Associates (2009) *Support Planning: tools to help you with your support plan*, HSA Press, UK available at http://www.hsapress.co.uk/publications/infocards.aspx

## Exploring Options in action:

| What do I want to achieve? | What do I have? | Traditional Option | Radical Option | Different Option |
|---|---|---|---|---|
| I want to get fit | My daughter is happy to exercise with me, or drive me to a group | Join the gym | Train for the Melbourne Marathon | Attend the local walking group twice a week |
| I want to take better care of my garden | I can afford to hire someone if I need to<br>I have built up garden beds and long handled gardening tools | Hire a gardener | Invite my family and friends over for a monthly working bee | Work with the Physio and OT to improve my balance and find ways to garden safely |
| I want to make new friends so that I don't feel so lonely | I go to Church every Sunday<br>I am fit and active | Join a Planned Activity Group | Start a 'phone circle' with other people from church | Look for a volunteer job that involves working with people |

## What we learned:

Joan has identifies a range of options about how she could approach each goal. The discussion has also allowed presentation of information about some local services and support that could support Joan.

# More conversation starters

The opportunities to learn about your client and understand their interests, priorities and goals are endless. At times though, it can be difficult to choose the right approach and find the perfect questions that will illicit the information you are looking for. Remember that there is no 'one size fits all' approach that will work every time, but the following questions may be useful to assist you to build rapport, establish expectations and begin goal setting and care planning.

**Ask broad, open questions to encourage the client to speak about themselves and share what's important to them.**

- Tell me about yourself
- What would you like to be doing that you're not doing at the moment?
- Is there something new that you would like to try or get involved in?
- Is there something that you used to do, that you miss and would like to do again?
- Do you get an opportunity to do the things you like to do?
- How would you like to spend your time?

You can then use more targeted questions to further explore issues that arise.

**Encourage the person to talk about their strengths, resources and interests?**

- What do you do really well?
- What are the things that you're managing well at the moment or feel good about?
- What motivates you to do things to improve your health and wellbeing?
- What's working really well for you at the moment that we could build on?
- What do people really like about you? If I asked your friends or family, what would they tell me about you?

**Empower the person to make suggestions and contribute their ideas about the support they would like.** This provides them with the opportunity to take the lead, set the direction and reinforces your commitment to collaborative planning.

- How can we best help/support you?
- Finish this sentence, 'If I could, I would …'
- What changes do you think would support you to improve your situation?
- What are you hoping for, when we work together?
- What would you like to work towards?
- What do you think are the most important things for us to work on?

For more information and ideas, refer to:

- The Department of Health Strengthening assessment and care planning: A guide for HACC assessment services in Victoria
- The Learning Community for Person Centred Practices Person centred thinking and planning
- Helen Sanderson Associates person centred thinking resources
- NSW Family and Community Service Lifestyle Planning Guidelines.

# Working through Challenges

This toolkit has reinforced that there is no 'one size fits all' approach to effective GDCP and that staff need to build rapport and work with each client as an individual. The HACC EMR GDCP project, has identified a number of issues though, that create challenges for goal setting and care planning. These include when the client has:

- Limited insight and has difficulties making decisions (e.g. due to Dementia or a cognitive impairment)
- Mental health concerns
- Communication difficulties (e.g. clients who are non-verbal)
- Clients with limited or no English and those from Culturally And Linguistically Diverse (CALD) backgrounds
- A terminal condition and/or is receiving palliative care
- Limited motivation or is resistant to care.

While each of these issues may create additional challenges, it is important to remember that the principles of person centred care, apply to all people. Therefore, staff need to ensure that they maintain an empowering, strengths based approach that values the individual needs and preferences of the client. Decisions about whether to set formal goals with clients should not be based on the client's diagnosis or prognosis. Instead, staff need to work with the individual and their carers to identify whether goal setting is appropriate and meaningful for them.

While, we advocate that the tools included in this toolkit, may still be appropriate for such clients, the following table outlines some approaches to support each of these client groups to develop appropriate, client centred care plans.

| Challenge | About the issue | Strategies | Useful tools & Resources |
|---|---|---|---|
| **Working with clients who are 'resistant' or express limited motivation for change** | Clients often access new services due to a change in their lives (health decline, crisis, functional change)<br>Clients can experience a range of emotions in response (frustration, disappointment, grief, anger)<br>These are all **normal responses**! | Explore what the client is resistant to (the assessment, the service, the approach, the loss of control, setting goals etc.).<br>Acknowledge the challenges and the associated emotions<br>Identify the client's strengths and utilise capabilities<br>Consider your timing…what's important right now? | 4 + 1 Questions (focus on the positives)<br>What's Working / What's Not Working<br>Important to vs. Important for |

| Challenge | About the issue | Strategies | Useful tools & Resources |
|---|---|---|---|
| **Supporting people who have limited insight and/or decision making abilities** | Client may have Dementia, a cognitive impairment, mental illness or intellectual disability (the factors impacting on the client's cognition need to be understood in order to work effectively)<br>Client does not have a clear understanding of the current situation<br>Client's expectations about the service's role, responsibilities or the capacity for change are unrealistic | Gather a rich past history (what makes the client 'tick')<br>Identify and build on the client's strengths and interests<br>Focus on building a sense of safety and trust<br>Allow additional time, and/or schedule a number of shorter sessions to ensure information is provided at a pace and format that is appropriate for the person<br>More frequent reviews may be required to ensure the care plan remains relevant<br>Dementia is a progressive condition, it is therefore important to consider the client's changing needs and plan ahead | Good days / Bad Days<br>Important to vs. Important for<br>What's Working / What's Not Working (utilise different perspectives)<br>If I could, I would …<br>DH: Strengthening assessment and care planning: Dementia practice guidelines for HACC assessment services<br>Alzheimer's Australia: Caring for someone with Dementia: Communication Fact Sheet<br>DoHA:Talking about dementia and dying |
| **Supporting clients who are living with a terminal condition and/or receiving palliative care** | Heightened emotions (client, family, carers)<br>Often clients experience a loss of control / power / choice<br>Some clients feel that they lose their identity as a person and are seen as 'the patient' | Prioritise +++<br>Empower client and carer/s with choices<br>Recognise and value the things that are important to the client, in order to reinforce your commitment to them as an individual<br>Plan ahead – acknowledge the need for flexibility, regular reviews and support as the client's care needs change.<br>Ensure that the client and carer have the information and resources required to access additional support if / when required | 5 Whys (what are they really hoping to achieve?)<br>Important to vs. Important for<br>Good Days / Bad Days (who can provide support and how?)<br>If I could I would …<br>Consider the need for Advance Care Planning<br>HSA Press: Person centred thinking: end of life |

| Challenge | About the issue | Strategies | Useful tools & Resources |
|---|---|---|---|
| **CALD and/or Non English speaking clients** | Different cultures view the role of health professionals differently and this may impact on a person's view about GDCP.<br>While a client's cultural identity is important, this is not the only factor that will impact on the way the client wants to engage with your service. Therefore, it remains essential to ask the person what's important to them, who they want to be involved in decision making etc. | Acknowledge that cultural identity and beliefs play an important role in the way we engage and work with services<br>Include an interpreter<br>Ask the client what is important to them and who they want to be involved in their decision making and care<br>Encourage others to be involved<br>Consider the traditional values and roles that families and carers play in different cultural groups<br>Check literacy prior to your appointment and before asking the client to sign any documents<br>Keep it Simple! | What's Working / What's Not Working<br>Important to vs. Important for<br>Create a communication chart with key phrases etc.<br>DH: Strengthening assessment and care planning: A guide for HACC assessment services in Victoria<br>BENSOC Research to Practice 4: Supporting older people from culturally and linguistically diverse backgrounds |
| **Working with clients with communication difficulties** | Clients who are non-verbal or have limited language skills | Ensure you understand how the person communicates and makes decisions (consider both receptive and expressive communication)<br>Be thoughtful of your non-verbal communication (e.g. body language, gestures and expressions)<br>Work with the client's strengths and enable them to make choices in appropriate ways<br>Utilise visual tools (e.g. using pictures, symbols, cue cards)<br>Encourage others to be involved | Develop a communication profile to create a clear picture of the client's preferred communication strategies (verbal & non-verbal)<br>Sharing receptive and expressive communication charts are a simple and easy way to share this information with everyone involved in the client's care |

# Chapter 3: Documenting quality care plans

This chapter is designed to provide guidelines and resources to support quality care plan documentation. It includes recommendations about the key components of effective GDCP documentation, an example of a GDCP template and an audit tool to support agencies evaluate and improve existing templates.

**'A goal without a plan is just a wish!'**
Larry Elder

## Why do we document care plans?

A care plan should provide a brief overview of the client's current situation; their goals and how you will work together to achieve those goals. Care plans are designed to be shared with the client and, where relevant, others involved in their care. When written well, a care plan can be an effective tool to:

- empower and motivate the client to actively participate in decisions about their care and share the responsibility for achieving positive results
- create a shared understanding with the client, their family, carers and other service providers about how you will work together to support the client achieve their goals
- monitor and track progress.

The EMR GDCP project included a survey of 72 clients and carers that asked about the importance and preferred processes for goal setting and care planning. 86% of respondents reported that they would like a copy of written information[11] about their care plan and identified their care plan as valuable to assist them to talk about their care with family / carers (48%) or other healthcare professionals (38%). This feedback reinforces that care plans can become an easy and effective communication tool that encourage information sharing.

## What constitutes a good quality care plan?

The EMR HACC GDCP project highlighted that while staff's ability to set goals and develop relevant actions is critical, the quality and usefulness of care plans is also dependant on factors related to both the:

- information that is documented on the care plan
- content and format of the care planning template.

11 Survey participants reported wanting the following written information: The actions that the staff are going to take to support me (61%), The goal/s we have agreed to work towards (55%), The contact details of the staff member/s I am working with in this service (54%), Information about other services that will be involved to help achieve my goals (49%) and The actions that we have agreed that my family and/or I will take to help me achieve my goals (40%).

## What to document

When developing care plans, it is important to keep in mind:

- **The intended audience of the care plan**

This may include the client, their family, carers and staff that are involved in the client's care (within and beyond your agency). Therefore care needs to be taken to use appropriate, inclusive language and avoid professional jargon or acronyms.

While a GDCP should always reflect the client's needs and priorities, it should be developed collaboratively and it is not essential that the care plan is documented in the client's own words. For many clients, it is more relevant to discuss key information and then work together to agree on the wording that will be included on the plan.

- **The purpose of the care plan**

It is intended to provide a brief summary of the client's needs, priorities and how you will work together – you don't need to include every detail on the care plan. Additional information should be documented in the client's case notes etc.

Many care plans include actions that will be completed by people who are not present when the plan is developed. The success of implementation is therefore reliant on creating a shared understanding of the client's goals and everyone (including the client, their family, carer/s, staff and volunteers involved in the client's care) being clear about the role they play in achieving them. Sharing the care plan is a simple and efficient way to support this information sharing, however staff should use their professional judgement to determine when additional information, resources and/or training are required.

Quality care plans provide an excellent framework for ongoing discussion, monitoring and review. This may, or may not be the role of the person who developed the care plan. The care plan needs to be easy to understand and each component should be clearly linked. When reviewing your care planning processes, it is useful to share examples with your colleagues – ask them to review the care plan and decide whether it includes enough information for them to be able to initiate a meaningful review conversation with the client.

## Initial care plan development


1. When the care plan was developed (date)
2. Who was involved in the development of the care plan
3. Information about the current situation that provides the context for the care plan and clearly demonstrates the links between the goals and actions (this information can also be used to review your approach in the future)
4. **Goal/s:** What the client / carer hopes to achieve (where relevant, SMART goals)
5. **Actions:** How you (along with the client, carer/s and other services) will contribute to achieving the goal/s. Include:
   a) The specific person / people responsible for implementing the action
   b) Timeframe for completion (remember that everything doesn't need to be actioned immediately)
   c) Space to record when the action is complete (this can be a simple checkbox) and if/when the goal has been achieved
6. Who the care plan has been (or will be) shared with

7. When the care plan will be reviewed
8. Acknowledgement that the client has understood and agreed to the care plan.

**Note:** The Victorian HACC program manual indicates that some service types are required to document additional information in their care plans (e.g. respite services are required to document emergency procedures as part of their care plan). Please refer to the HACC program manual to identify specific documentation requirements relevant to you.

## Documenting the implementation of actions and the outcomes of formal and informal monitoring / feedback

1. **Actions should be recorded and dated on the care plan as they are completed.**

   Monitoring is an ongoing process that is supported by regular communication and feedback from those involved in implementing the care plan. This can occur formally or informally but it is important that communication pathways are agreed in order to maintain open communication and ensure that all participants are acknowledged as valuable contributors and empowered to provide relevant input.

   Regular monitoring enables issues or barriers to be identified and addressed quickly. It also provides the opportunity to celebrate successes and acknowledge the contributions and achievements as they are made.

   Feedback should be documented and actioned appropriately, according to the organisation's policies and procedures.

2. **All changes made to the client's care plan need to be dated and should include a brief description of the change and its rationale.**

## Documenting care plan reviews

Care plans need to remain 'living documents' and should be adapted over time to reflect the changing needs of the client.

A summary of the outcome of a review can be documented on the original care planning template, or on a separate tool. This may, at least in part, be determined by an agency's IT and client record systems. Organisations should therefore develop a consistent process that is relevant and practical within the context and systems of their service.

Review documentation should include:

1. **Date of review**
2. **A summary of the client's current status, highlighting changes that have occurred since the development of the plan (or previous review)**
3. **The impact of completed actions on the achievement of the client's goals and outcomes**

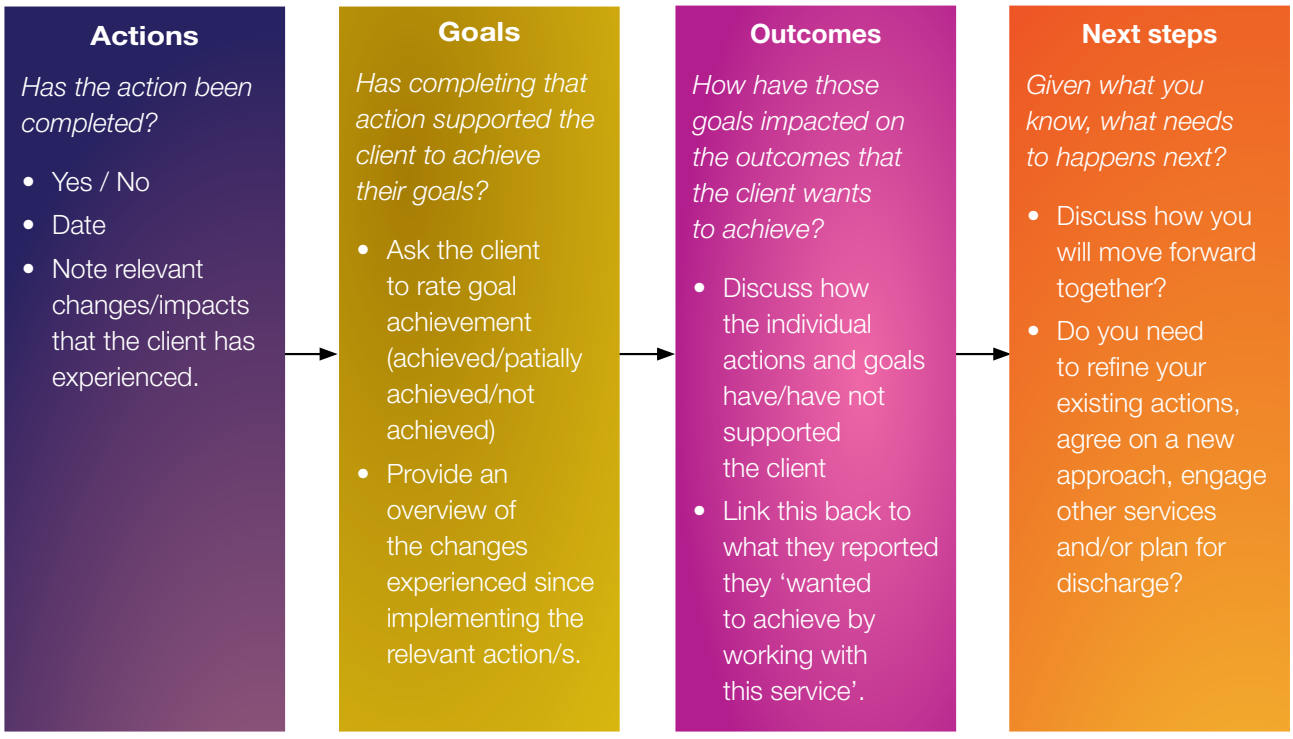
   This can be reported using a scale (e.g. Achieved / Partially Achieved / Not Achieved) however this should be supported by a brief description of the changes that have occurred. Further information may also be recorded in the client's progress notes / record.

   Progress should be evaluated collaboratively. Some goals can be measured objectively (e.g. I want to be able to walk to the local shops independently by the end of January), however the achievement of other goals will require a subjective assessment (e.g. improved confidence or sense of safety). In the latter example, staff should support the client to discuss their perceptions of the change that has occurred and rate their goal achievement.

   The completion of actions and achievement of goals should also be linked back to whether this has supported the client to achieve their desired outcomes (e.g. what they wanted to achieve by working with your service).

4. **Next steps**

   Based on the outcome of your review, new and revised goals and actions should be documented (as per the documentation guidelines stated above).



## Effective care planning templates

While the Victorian HACC program manual describes the need for GDCP across all HACC services, it does not mandate the use of a specific care planning template. Best practice literature demonstrates that user-friendly care plans should be a **short 1-2 page summary** of key information that is written in a simple, **easy to read format**. The EMR HACC GDCP project also identified the following features that led to better quality documentation:

- Ensuring that the format makes it clear which actions relate to each goal
- Including a prompt, written as a question, that asks about the client's overall goal for engagement (e.g. What are you hoping to achieve by working with our service?)
- Including space to document the outcomes of your review, or follow up information when actions are completed.

Care plans should be 'living documents' that are reviewed and updated regularly to ensure they remain relevant and useful. Therefore, when developing care planning templates, organisations need to consider how and where staff will document the outcomes of such reviews and strategies to revise the care plan. This is particularly important for organisations that maintain electronic client records.

> A great care planning template is never enough! In order to be effective, implementation support, including staff training and clear documentation guidelines, is essential.

## The Goal Directed Care Planning template

The GDCP template was developed as an example of how the key elements of good templates can be integrated into a simple and appropriate tool. The template has been trialled by HACC staff in approximately 50 case studies and, when compared to care plans completed using a range of alternative templates, the quality of completed care plans was shown to increase when using this template.

While this template is deemed broadly applicable across the HACC sector, we recognise the need for flexibility and therefore encourage agencies to review and refine the template to meet the needs of their clients, staff and organisation.

The template is included on the following page. *Please refer to Appendix 2 to review examples of completed care plans using this tool in different HACC service types*.

## Shared Care Planning

Shared care plans are required when the client requires support / services from multiple programs and/or services. It is an overarching plan, designed to provide an overview of the client's care across all services and is often developed by the client's key worker (or a nominated representative of the care team). The assessments and care plans developed by each staff member / agency will therefore contribute to, and inform the shared care plan. The Victorian HACC program recommends the use of the Shared Support Plan SCTT template to support consistent shared care planning. This template can also be used and/or adapted for use as a general care plan.

# Goal Directed Care Planning Template

| | | | |
|---|---|---|---|
| Name: | | Date Care Plan Developed: | |
| People Involved: | | Date for Review: | |

| What do you want to achieve by working together? |
|---|
| |

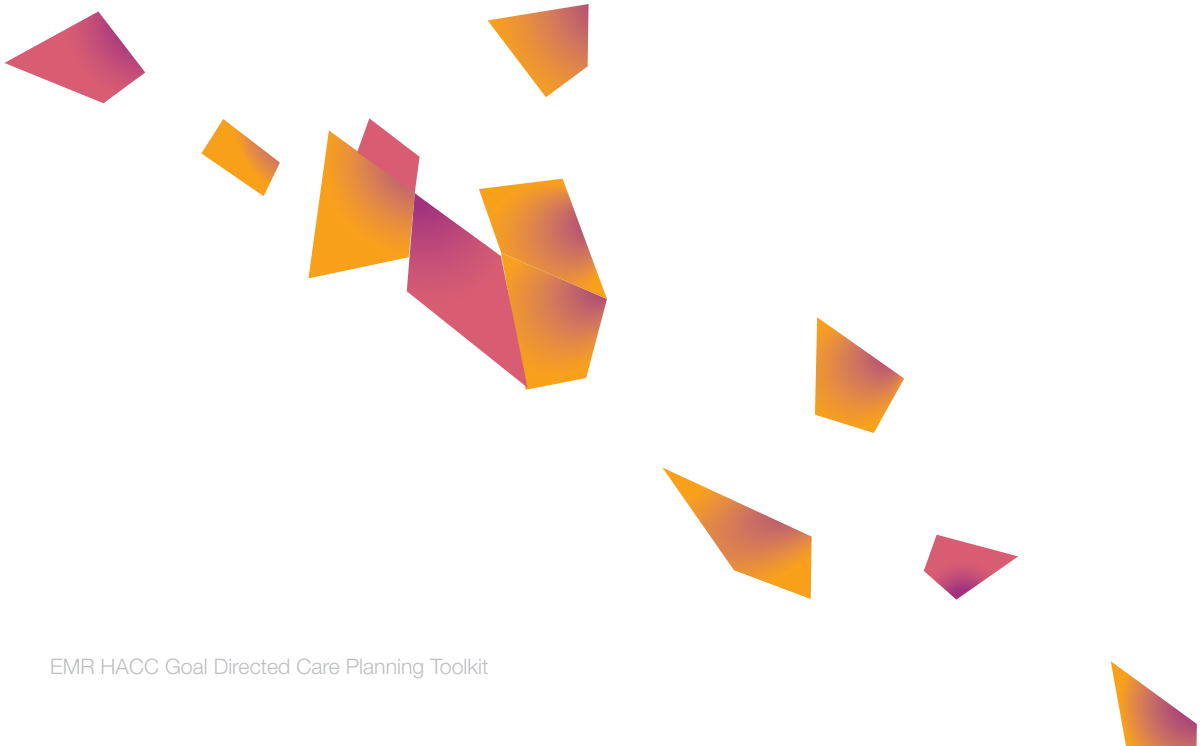
| Current situation | Goal | Actions | Person responsible | Timeframe | Completed | Outcomes |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Care plan provided to: | | Client Yes / No | |
|---|---|---|---|
| Family / Carer | Yes / No | Name/s: | Client Consent: Yes / No |
| Other Staff | Yes / No | Name/s: | Client Consent: Yes / No |
| Other Services | Yes / No | Name/s: | Client Consent: Yes / No |
| **Client Acknowledgement:** I understand and agree to this care plan | | **Client:** | **and/or Carer:** |

## The audit tool for care planning templates

In addition to the GDCP template, we have created an audit tool that evaluates care planning templates against 11 key elements (related to initial care plan development). This tool can be used to evaluate your existing care planning template and/or to inform the development of a new template. The completed audit tool will provide you with tangible information about the strengths and weaknesses of the template and concrete ideas about opportunities for improvement. *Please refer to Appendix 3 for examples of care planning templates that have been audited using this tool.*

| Audit Criteria | Rationale | Scale |
|---|---|---|
| **The care planning template provides clear space to document:** | | |
| 1. The date of development of the care plan | Readers should be able to quickly identify when the care plan was developed. | 1 – Yes<br>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<br>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<br>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<br>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<br>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<br>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<br>0 – No |
| 7. The person / people responsible for implementing each action | In order to demonstrate clear accountability, a specific person should be assigned responsibility 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<br>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<br>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<br>0 – No |
| 10. A date when the care plan will be reviewed | Care plans should be regularly reviewed so that the goals and associated actions remain current and relevant | 1 – Yes<br>0 – No |
| 11. Client Acknowledgement | Acknowledgement that the client and/or carer has understood and agreed to the care plan. Where appropriate, clients and carers should sign the care plan, alternatively verbal acknowledgement can be documented by staff. | 1 – Yes<br>0 – No |
| **TOTAL** | | **…. / 11** |



# Chapter 4: Organisational Systems that support GDCP

In addition to skilled and enthusiastic staff, there are a range of organisational factors that impact on the success of GDCP approaches. Aimed at program leaders and managers, this chapter provides an overview of the organisational systems (such as policies and procedures) that support staff to embed a best practice approach. It includes a checklist that organisations can work through to identify and prioritise areas for ongoing improvement.

Best practice guidelines highlight a range of organisational factors that enable staff to effectively embed person centred care. These include:

- Employing skilled, knowledgeable and enthusiastic staff, with excellent communication skills and a commitment to the principles and practices of holistic, strengths based and goal oriented service delivery
- Ensuring clients and carers are actively involved in decision making about their care
- Organisational leaders and managers actively supporting the approach and celebrating good practice
- Enabling staff to reflect on their practice, values, beliefs and approaches
- Providing appropriate staff training and professional development opportunities
- Delivering care in appropriate and supportive environments
- Creating organisational policies and procedures that are supportive of good practice
- Building strong partnerships with other local service providers.

The literature also describes a range of factors that act as barriers to embedding person centred approaches. The most common reported barriers are time limitations, inflexible systems and scheduling, staff lacking autonomy to make client focussed decisions and a lack of clarity about how the principles and processes apply to the context of the organisation and/or program.

The importance of implementing relevant organisational systems is reflected in the Victorian HACC Program Manual and the HACC quality framework. Standards and processes relevant to GDCP are consistent across the health and community service sectors. In HACC these standards are articulated in the:

- Community Care Common Standards (CCCS) (and the associated Victorian HACC Quality Review Resource)
- Victorian Service Coordination Continuous Improvement Framework (2012)

*Please refer to Appendix 4 for a summary of GDCP and related quality standards.*

# Checklist of organisational systems to support effective GDCP

This checklist has therefore been developed to support agencies review their progress in relation to developing organisational systems that support effective GDCP.

## How to use the checklist

For many agencies, achieving all of the elements outlined below will require significant work. It is recommended that you adopt a graded approach:

1. Work through the checklist with a selection of key staff in order to establish your current strengths and opportunities for improvement
2. Prioritise the changes required and develop an action plan
3. Choose one or two changes to make at a time. Develop the appropriate systems, pilot and review its appropriateness and effectiveness to support your staff.

| Checklist of Organisational Systems to support effective GDCP | Yes | Partially | No |
|---|---|---|---|
| **Leadership** | | | |
| Our leadership team has a solid understanding of the principles of GDCP and actively support this as a strategy to support person centred care | | | |
| Our HACC program managers and team leaders champion good GDCP practice and actively support ongoing learning | | | |
| **Organisational Policies**<br>Effective GDCP is reliant on maintaining a flexible approach that is responsive to the needs of the client. Staff should therefore be empowered to utilise their expertise and experience to decide on the best approach to build rapport, discuss goals and develop an appropriate care plan for each client. Organisational policies should therefore focus on the principles of goal oriented care planning (rather than describing a prescriptive process) | | | |
| **The principles of GDCP are reflected in our organisation's:** | | | |
| • Vision and mission statements | | | |
| • Human Resources policies and resources (including recruitment information, position descriptions, staff workplans, performance appraisal tools etc.) | | | |
| **Our organisation's policies clearly articulate:** | | | |
| • how GDCP (and a person centred approach more broadly) is applied in the context of our service | | | |
| • our commitment to actively engaging clients, carers and other relevant people (including other agencies) in goal setting and care planning processes | | | |
| • the ability for staff to use their professional judgement to determine if and when formal goal setting is appropriate for an individual client | | | |
| • the circumstances in which goal setting may be deemed inappropriate for a client (within the context of your agency) and the process to document this appropriately | | | |

| Checklist of Organisational Systems to support effective GDCP | Yes | Partially | No |
|---|---|---|---|
| • that care plans are developed and shared with the client and (given consent) other people involved in the client's care (such as carers, family members, staff, volunteers and external service providers) | | | |
| • the circumstances under which developing a care plan is not deemed relevant and the process to document this appropriately (including the rationale)<br>*NB: There are times when formal goal setting and care planning processes are not appropriate (e.g. when client has recently completed a holistic assessment and care plan with another service and/or the client is attending your service for a one-off intervention / education session).* | | | |
| • monitoring strategies that we consider appropriate for our client group (e.g. phone, face to face, formal and informal information collection) | | | |
| • strategies to ensure clients, carers, staff and volunteers involved in the delivery of a client's care can provide formal and informal feedback about the implementation of the care plan (and how this information is recorded, collated and used to inform client care) | | | |
| • the indicators for the review of a client's care plan or a formal re-assessment of a client's needs<br>*NB: indicators should describe timeframes for periodic reviews as well as reviews initiated based on the changing needs or circumstances of the clients* | | | |
| **Service Coordination** | | | |
| Our organisation maintains strong working relationships with our local partners (within and beyond the HACC sector) and has clearly articulated referral pathways and protocols to support shared clients<br>*NB: Please refer to the Victorian Service Coordination Practice Manual for further information about strategies to support the coordination of care* | | | |
| **Staff Orientation and Training** | | | |
| Opportunities for staff to develop and maintain skills relevant to effective GDCP are integrated into ongoing professional development plans, including: | | | |
| • Staff orientation | | | |
| • Training calendars | | | |
| • Team meetings / peer support | | | |
| • Interagency networking and training opportunities | | | |
| • Openly acknowledging and rewarding good GDCP practice | | | |

| Checklist of Organisational Systems to support effective GDCP | Yes | Partially | No |
|---|---|---|---|
| **Service Information and Management Systems** | | | |
| Our **rostering and time management systems** are flexible and enable staff to allocate time for client assessment, care planning and review according to the needs of the individual client (e.g.: staff have the flexibility to complete an assessment and/or develop a care plan over multiple appointments, time is dedicated to enable follow up and coordination of services) | | | |
| Our **Marketing and promotional materials** reflect a commitment to person centred, goal oriented service delivery.<br>*NB: The Active Service Model communication toolkit contains a range of tools and resources that can assist agencies in the development of communication materials for clients, carers, other service providers and the broader community.* | | | |
| Our organisation maintains **GDCP tools and templates** that align with best practice guidelines and these are regularly reviewed to ensure they remain relevant and user-friendly for staff and clients<br>*NB: Refer to Chapter 4 Care plan documentation, for further information* | | | |
| Our **client record system** enables staff to document, review and update care plans efficiently and effectively (consider paper based and electronic systems) | | | |
| **Ongoing Quality Improvement** | | | |
| Our organisation supports a cyclical approach to quality improvement, which provides systematic review, evaluation and refinement of service delivery | | | |
| Appropriate data collection and reporting mechanisms are in place to support the evaluation of GDCP<br>*NB: Refer to Chapter 6: Evaluating your approach, for further information* | | | |
| Our organisation actively seeks feedback from clients and carers in relation to the planning, delivery and evaluation of our services | | | |

# Chapter 5: Evaluating your approach

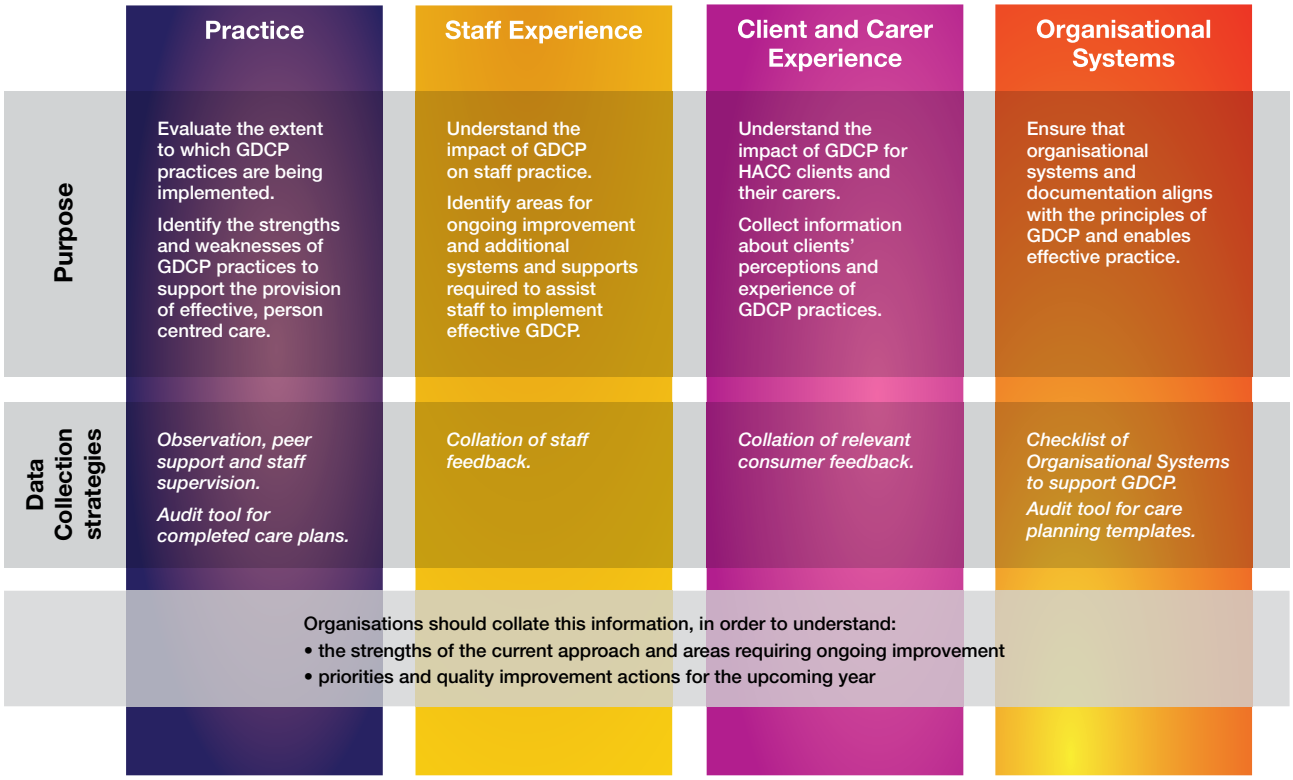
This chapter provides a framework that can support HACC agencies to evaluate and monitor their GDCP approaches. This will assist you to:

- understand the strengths and weaknesses of your current approach and systems
- track your implementation progress
- quantify the impact of any changes that you make.

This evaluation information will also be valuable to support your reviews against the Community Care Common Standards (CCCS)[12].

It is important to note that this toolkit provides a range of suggestions. These should be modified to fit into your agencies' broader quality improvement systems. It is also important to recognise the need for a graded approach to implementation – as new systems or practices are developed, supportive evaluation strategies should be included. This will ensure that you can continue to learn about, and modify your approach over time.

The diagram below, provides an overview of the different perspectives from which you can evaluate your GDCP approach. Remember however, that it will take time to embed the changes and begin to see results! Building evaluation systems early, allows you to collect baseline information and then track progress over time.




Over the following pages, each of these four elements are explored, including suggestions regarding tools and strategies that can support you to evaluate your practice.

*Please refer to Appendix 5 for a full page version of this diagram.*

12 The evaluation framework is also relevant to, and consistent with other quality improvement frameworks and accreditation programs.

## Evaluating your Organisational Systems

As discussed in previous chapters, in order to effectively embed GDCP, staff need to be supported with appropriate tools, ongoing professional development and relevant organisational systems. In order to review your systems and documentation against best practice and accreditation standards, we recommend using the:

- Checklist of Organisational Systems to support GDCP (see Chapter 4)
- Audit tool for care planning template (see Chapter 3).

## Evaluating practice

Evaluating current practice will provide you with information about:

- The extent to which GDCP processes are being implemented (e.g. compliance with organisational processes, use of tools)
- The quality of goal directed care plans being developed
- The strengths and weaknesses of current GDCP processes.

To evaluate practice, you can observe staff as they set goals and develop care plans with clients and/or audit completed care plans.

### Observation

Direct Observation, by an experienced team member is the best strategy to evaluate:

- the appropriateness of documented goals and actions (i.e.: has the staff member documented the highest priority goals and developed the best solutions)
- the processes undertaken to identify the documented goals and actions (i.e. has the staff member asked the right questions and interpreted information correctly when developing the care plan).

## The audit tool for completed care plans

This tool has been developed to support the evaluation of completed care plans. It includes 28 criteria that describe the key information that should be documented during the development and review of care plans.

It is important to note that the audit tool is designed to evaluate the content and communication of the care plan. However, it may also raise questions as to how the process was completed. For example, an issue may be identified and documented on the GDCP template that is beyond the scope of your service. Good practice would suggest that relevant actions may include consideration of, and potentially, referrals to other service providers. If a staff member repeatedly fails to document consideration of the need for other services, this may indicate a need for further education / support, which can be addressed during supervision, team meetings, case conferences or via professional development opportunities.

# How to use the audit tool for completed care plans

This audit tool can be used for a range of purposes, both as an educational resource to build knowledge and awareness about effective documentation, and to support ongoing quality improvement. This may include:

## Team meetings

To reinforce GDCP skills, the audit tool can be used to evaluate a random sample of completed care plans from the team. Staff can participate in the evaluation of their own, and other team members case studies and then discuss the strengths and weaknesses of completed care plans. This approach values the expertise and experience of team members and provides an excellent opportunity for peer discussion, mentoring and shared problem solving. The audit results may identify issues for individual improvement and/or key themes that require revision across the team.

In order to promote open communication, it may be beneficial to de-identify the case studies prior to review.

## During Staff Supervision

The audit tool can be used during supervision to review a sample of a staff member's completed care plans, in order to understand and reflect on current practice. The results can then be used to highlight strengths, identify strategies to improve practice and understand professional development priorities.

## Case conferences / team discussions

The audit tool can be integrated into case conferences, particularly of shared clients, to review the quality and content of the completed care plan. This is particularly valuable for shared clients, where staff will be able to discuss whether the care plan accurately reflects the client's needs, priorities and the relevance of documented actions. The progress of the care plan may also be regularly reviewed via the case conference.

## File Audits

File audits are an integral component of quality improvement processes in the HACC program and collect important information for performance evaluations, quality improvement and accreditation. The audit tool can be completed as a stand alone audit, or the criteria can be integrated into existing file audit tools, to enable periodic review and monitoring of care planning documentation.

**Important Considerations:** It is recommended that when staff are beginning to use the audit tool, it be completed by two staff members, who rate each care plan independently and then compare results. Where discrepancies in scoring exist, these should be discussed and any misunderstanding clarified to promote reliability reliability.

*Please refer to Appendix 3 for examples of audited care plans. These can be used for reference and training purposes.*

## Audit Tool for Completed Care Plans

| Audit criteria | Rationale | Scale |
|---|---|---|
| 1. The client has a documented care plan | A care plan should be documented utilising the approved template / format that provides an overview of the way in which the service will support the client achieve their goals | 1 – Yes<br>0 – No |
| 2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented. | It is not always appropriate to formally set goals and develop a care plan for a client, however the rationale for not completing the care plan should be documented as per organisational procedures | 1 – Yes<br>0 – No<br>0 – N/A |
| 3. The date that the care plan was completed is recorded | Readers should be able to quickly identify when the care plan was completed | 1 – Yes<br>0 – No |
| 4. The people involved in the development of the care plan are recorded | 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 and organisations where relevant) | 1 – Yes<br>0 – No |
| 5. The writing in the care plan is legible | In order to be useable, a care plan needs to be easily able to be read | 1 – Yes<br>0 – No |
| 6. The language used in the care plan is appropriate to the client | The care plan should be written in language that is appropriate to the client, without the use of complex terminology or acronyms. | 1 – Yes<br>0 – No |
| 7. The care plan provides an overview of the current context / current situation | The care plan should include a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This should provide adequate detail to enable to reader to understand how the subsequent goals fit into the clients overall life or context. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns | 2 – Always<br>1 – Somewhat<br>0 – Never |
| 8. The goals set clearly demonstrate what the client hopes to achieve | The goals should identify what the client hopes to achieve (in the short or long term). The goals may include hopes within and beyond the scope of services provided by your organisation. | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals | The documented action/s should provide an overview of how staff will work with the client and other relevant people (including carers, family and other service providers) to support the achievement of each goal | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 10. There are appropriate timeframes recorded for when each action will be completed | Specific timeframes should be articulated for each action, and reflect the client's needs and priorities. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process.<br>For some actions (e.g. sending a referral), it is relevant to define a specific date for completion. For other actions (e.g. daughter to provide transport until volunteer driver in place) it may be more appropriate to record a timeframe (i.e. 4-6 weeks) | 2 – Always<br>1 – Sometimes<br>0 – Never |

| Audit criteria | Rationale | Scale |
|---|---|---|
| 11. The person / people responsible for implementing each action are documented | 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 | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 12. There is a clear link between the actions and goals that are documented | Based on the care plan alone, readers should understand how each action relates to achieving the relevant goal/s | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals. | A person centred approach requires staff to think beyond the scope of their service and support clients to address their goals in a holistic way. The care plan should reflect that, where appropriate, the client has been supported to access other relevant services to achieve their goals (e.g. via communication with and/or referrals made to other team members / organisations) | 2 – Always<br>1 – Sometimes<br>0 – Never<br>0 – N/A |
| 14. There is evidence that the care plan is individualised and client centred | In order to be person centred, the goals set should reflect the individual needs and wishes of the client and be clearly linked to the client's current situation / context. Goals and actions that are generic or reflect the services needs are not appropriate to be documented on a care plan | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 15. A date or timeframe has been documented for when the whole care plan needs to be reviewed | In order to remain relevant, care plans need to be regularly reviewed. The time frame set for review will depend on the type of goals set and the timeframes for the achievement of these goals | 1 – Yes<br>0 – No |
| 16. 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<br>NB: Documentation of verbal acknowledgement is also appropriate | 1 – Yes<br>0 – No |
| 17. There is evidence that a copy of the care plan was provided or offered to the client | In order for a care plan to be acted on by the client, they need written documentation as a record of the process | 1 – Yes<br>0 – No |
| 18. There is evidence that, where appropriate, the care plan has been shared with relevant people | Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers) | 2 – Always<br>1 – Sometimes<br>0 – Never<br>0 – N/A |
| | | **CARE PLAN DEVELOPMENT TOTAL ..... / 26** |

| Audit criteria | Rationale | Scale |
|---|---|---|
| **Additional Criteria for Care Plans that have undergone one or more reviews:** | | |
| 19. The date that the care plan was reviewed is recorded | Readers should be able to quickly identify the date/s when the care plan was completed<br>If multiple reviews have been completed, all dates should be clearly documented | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 20. The people involved in each review of the care plan are recorded | The names of the people involved in care planning should be clearly documented (including roles and organisations where relevant). This may include people who have been consulted / provided feedback that informs the review and revision of the care plan (including carers, friends, family and other service providers) | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 21. The client's current context ./ current situation is updated to reflect the changing circumstances at each review | A very brief summary of the client's current situation should be included in each review, highlighting changes in function, needs, priorities etc. | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 22. Actions have been completed in accordance with the time frames set | This provides evidence that the care plan has been utilised and maintained accordingly | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 23. The impact of completed actions is documented in relation to goal achievement / outcomes | The completion of actions need to be linked back to whether this has supported the client active their desired outcomes (i.e. what they wanted to achieve by working with your service). | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 24. Outstanding issues / next steps are noted | Outstanding issues need to be noted, demonstrating the rationale for revisions to the care plan (i.e. why actions are abandoned or modified and/or where alternative strategies are required to effectively support the client achieve their goals). Next steps are documented accordingly. | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 25. Where goals are inactive or no longer relevant, the reasons why are clearly documented | Goals may become irrelevant or inactive and the reasons why need to be clearly documented to assist with future care planning | 2 – Always<br>1 – Sometimes<br>0 – Never<br>2 – N/A |
| 26. Client acknowledgement | Revisions conducted as a result of care plan review should be signed off by the client<br>NB: Documentation of verbal acknowledgement is also appropriate | 1 – Yes<br>0 – No |
| 27. There is evidence that a copy of the revised care plan was provided or offered to the client after each review | Clients should be offered a copy of the care plan each time it is formally reviewed / revised | 2 – Always<br>1 – Sometimes<br>0 – Never |
| 28. There is evidence that, where appropriate, the care plan has been shared with relevant people | Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers) | 2 – Always<br>1 – Sometimes<br>0 – Never<br>2 – N/A |
| | | **CARE PLAN REVIEW TOTAL (Q 19 – 28) ..... / 19** |
| | | (Add Development + Review Totals) **TOTAL ..... /45** |

## Evaluating staff's experience

By collecting information directly from staff, you will be able to understand:

- the impact of GDCP on staff practice
- the staff's experience of goal setting and care planning, including current strengths and priorities for improvement to assist staff to implement effective GDCP
- staff training needs.

In order to support open communication and collaborative problem solving, it would be useful to conduct a feedback session with HACC staff (e.g. in a team meeting). Additional information can be collected during staff supervision, performance appraisals and via informal feedback mechanisms.

| Staff Feedback: Proposed Questions |
| --- |
| How confident do you feel about your ability to set goals and develop care plans for your clients?<br>*NB: Use a 10 point rating scale to rate answers. If you complete this annually, you will be able to effectively track staff confidence over time.* |
| What are you currently doing that works really well in setting goals and developing care plans for your clients? |
| Do you think our current goal setting and care planning processes are useful for clients?<br>• Why / Why not?<br>• Are we providing clients with the right information about their care plan? |
| How does our GDCP approach impact on the way you work with HACC clients? |
| What are the challenges that you face in relation to goal setting and care planning? |
| What could we do differently in order to improve our approach to goal setting and care planning? |
| What other GDCP initiatives or practices are you aware of that we could utilise to improve our systems? |
| Do our current practices make it effective and efficient for you to develop GDCP with your clients?<br>• Why / Why Not?<br>• How could this be improved?<br>• What resources and supports do you need to make this easier? |

Also consider strategies to collect feedback from other staff and volunteers who are involved in delivering client care (but not necessarily developing care plans). This may include direct care workers, allied health assistants, volunteers and support staff. Suggested questions:

- Do you feel able to provide feedback about client care plans?
- When you have concerns about a care plan, how would you raise them?
- Do you feel that's an appropriate strategy? Why / Why not?
- When you do provide feedback, do you feel that is listened to and used to make the relevant changes?

# Evaluating the client and carer's experience

Collecting feedback from clients and carers will enable you to understand:

- The impact of GDCP on the experience of HACC clients and their carers
- Clients' perceptions of GDCP and their preferred approaches.

When collecting feedback from clients and carers, remember to keep it simple! While a range of questions are included below, it is often preferable just to ask a couple of key questions at a time.

## Surveys

Surveys are often an efficient and affordable way to collect feedback, however you need to be thoughtful about whether this is appropriate and relevant for your client group. If you are developing a questionnaire, make sure you test it with a small group before you distribute it to your clients. Also, be thoughtful about the format you use to ask the questions. For example, surveys could be:

- left in the waiting room for clients and carers to complete anonymously
- given directly to clients during or after an appointment
- online surveys may be appropriate for some clients.

## Interviews

Alternatively, interviews can be conducted over the phone, or face to face. This way, you can integrate a couple of key questions into your conversation. This less formal approach works well for many clients. Be thoughtful about:

- who will conduct the interview (clients are unlikely to provide constructive criticism directly to staff involved in their care)
- how you will record and collate the information (qualitative information is more difficult, and can be time consuming to analyse).

Also look at other ways to collect feedback from clients and carers. This could include:

- Maintaining a log of informal feedback
- Integrating a couple of targeted questions into review sessions
- Collating information from existing consumer feedback systems (e.g. compliments and complaints)
- Embedding regular feedback sessions into a group program (you could use the what's working / what's not working tool)
- Creating a suggestions box.

| Client and Carer Feedback: Proposed Questions | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Were you given an opportunity to talk about what you wanted to achieve by working with our service?** | | | | **Yes** | | **No** | **I'm not sure** |
| **Did you find that helpful?** | No, not at all | | | | | | Yes, Very helpful |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Why / Why not? | | | | | | | |
| **Do you think the staff listened to, and understood what was important to you?** | No, they didn't listen to what I wanted at all | | | | | | Yes, they listened to me and understood what was important to me |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Why / Why not? | | | | | | | |
| **Did you feel like you were able to make decisions about the way we work together?** | No, they didn't listen to what I wanted at all | | | | | | Yes, they listened to me and understood what was important to me |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Why / Why not? | | | | | | | |
| **Have you been given enough opportunities to provide feedback and make changes to the way we provide services?** | | | | **No** | | **I've had some opportunities, but I would like more** | **Yes** |
| Why / Why not? | | | | | | | |
| **Was the written information you were given about your care plan helpful?** | | | | **No** | | **Somewhat** | **Yes** |
| Why / Why Not? | | | | | | | |
| What other information would have been valuable for you? | | | | | | | |

***Note:*** *It is not realistic to expect that these survey findings will provide concrete evidence of the impact or effectiveness of specific interventions. It will however provide you with an overview of how your clients perceive their experience, which is valuable to guide your ongoing quality improvement.*

# Resources

## Victorian HACC resources

Strengthening assessment and care planning: A guide for HACC assessment services in Victoria: http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf

Strengthening assessment and care planning: Dementia practice guidelines for HACC assessment services: http://www.health.vic.gov.au/hacc/downloads/pdf/dementia_guidelines.pdf

The Active Service Model: http://www.health.vic.gov.au/hacc/projects/asm_project.htm

Victorian HACC Program manual: http://www.health.vic.gov.au/hacc/prog_manual/index.htm

HACC Quality framework: http://www.health.vic.gov.au/hacc/quality_frmwrk/index.htm

Community Care Common Standards (CCCS): http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-qualrep-standards.htm

Victorian HACC Quality Review Resource: http://www.health.vic.gov.au/hacc/downloads/pdf/quality_resource2012.pdf

Victorian Service Coordination Practice Manual: http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Victorian Service Coordination Continuous Improvement Framework: http://www.health.vic.gov.au/pcps/downloads/continuous.pdf

Diversity Planning and Practice: http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm

Framework for assessment in the HACC program in Victoria: http://www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf

Local care planning project information, resources and research are available at http://www.health.vic.gov.au/pcps/coordination/care_planning.htm

## Competency based training

Implement Goal-directed Care Planning: This nationally recognised training unit is designed to provide skills and knowledge in care planning for a broad range of practitioners across the community and health sector. Available at: http://www.health.vic.gov.au/pcps/goaldirected.htm or http://training.gov.au/Training/Details/CHCCM702B

## Other Australian HACC Programs

A number of other projects are happening across Australia's HACC sector that support a strengths based, enabling approach to HACC service delivery.

**Western Australia:** The Wellness Approach: Available at: http://www.communitywest.com.au/Wellness/introduction-to-the-wellness-approach.html

Goal Setting: A resource for WA Home And Community Care staff: This resource has been developed as an **introduction** to provide you with information and an understanding of goal setting, how to set goals and assist clients to achieve their goals. This tool covers communication suggestions and prompts when discussing goals with your clients, breaking client goals into steps and why it's important to support your clients to achieve their goals. Available at: http://www.communitywest.com.au/Sector-Development-News/goal-setting-resource-guide.html

**NSW:** The Better Practice Project: Available at: http://www.adhc.nsw.gov.au/sp/delivering_hacc_services/the_better_practice_project

Towards an enabling approach in community care: Available at: http://www.adhc.nsw.gov.au/__data/assets/file/0010/233965/Better_Practice_Project_-_Discussion.pdf

## Person Centred Care

Many of the tools outlined in Chapter 2 of this toolkit include person centred concepts, principles and materials used with permission from the Learning Community for Person Centred Practices and Helen Sanderson Associates. Their websites provide a huge range of resources to support person centred thinking and planning across a range of service types.

**Helen Sanderson Associates:** http://www.helensandersonassociates.co.uk/

Of particular interest may be:

Person Centred Thinking: Reablement minibook: Available at: http://www.hsapress.co.uk/media/14568/reablementminibook.pdf

Person centred thinking minibook (Australian version): Available at: http://www.hsapress.co.uk/media/9855/hsaminibookaus.pdf

Using person centred planning approaches with children and their families: Available at: http://www.helensandersonassociates.co.uk/media/10132/using%20person%20centred%20planning%20and%20approaches%20with%20children%20and%20their%20families.pdf

**The Learning Community for Person Centred Practice:** http://www.learningcommunity.us/

Of particular interest may be:

One page profiles: Available at: http://www.learningcommunity.us/onepageprofiles.htm

Person centred thinking and planning: Available at: http://www.learningcommunity.us/documents/pctandplanning.pdf

**NARI:** Person Centred Health Care: Available at: http://www.mednwh.unimelb.edu.au/pchc/index.htm

What is person-centred health care? A literature review (NARI 2006): Available at: http://docs.health.vic.gov.au/docs/doc/14874FC8EFAC1D62CA25792B0077C631/$FILE/litreview.pdf

**NSW Family and Community Service:** *Lifestyle Planning Guidelines* are designed to support planning with people with disabilities, utilising a person centred approach. The guidelines include practical information about how to explore a person's priorities, goals and make decisions about care. The team has developed a number of templates for the person centred thinking tools with easy to read descriptions and examples. There is also a helpful tip sheet that provides advice about when to use each of the tools.

**Benevolent Society:** Research to Practice Briefings on Community Aged Care:

The briefings summarise the research about a specific aspect of community care, with an emphasis on the significance of the research findings for the day-to-day work of care practitioners with older people. The Briefings are concise (8 pages), in straightforward language and are designed especially for case managers, coordinators, team leaders and managers. The Briefings are produced by The Benevolent Society in collaboration with academic partners, for a national audience. Our aim is to help build a culture of evidence-informed practice in community aged care services and thus contribute to improvements in older people's wellbeing. Available at: http://www.benevolent.org.au/think/practice--resources

# Appendix 1: Overview of the EMR HACC Goal Directed Care Planning Project

## THE EMR GOAL DIRECTED CARE PLANNING PROJECT

The Eastern Metropolitan Region's (EMR) Goal Directed Care Planning (GDCP) project has been established in order to build the skills, knowledge and confidence of relevant HACC staff across the EMR for effective GDCP. As such, the project adopted a regional approach, bringing together staff from a range of agencies to share their experiences, knowledge and existing tools. Reflective practice and action learning principles were utilised, ensuring that learnings from each project phase informed the design of subsequent phases.

| | Goal | Actions | Key Learnings |
|---|---|---|---|
| **Phase 1 Review** | Review the current application of GDCP across the EMR HACC sector in order to understand the strengths and weaknesses of existing approaches/tools and identify organisational systems in place to support GDCP. | *Literature review:* to explore current theory, best practice guidelines and resources to support GDCP (relevant to the HACC sector).<br>*Staff Consultations:* staff forums to explore perceptions of GDCP, strengths and challenges of current approaches and priorities for ongoing work.<br>*Current Practice survey:* focussed on current practice and organisational systems to support GDCP.<br>*Case studies:* including submission of de-identified care plans (x 2) and reflective questionnaires.<br>*Client Survey:* 72 HACC clients surveyed to explore their perceptions about GDCP and preferred approaches. | Strong body of evidence available regarding the benefits of GDCP in supporting person centred care. Many tools available however participants reported lack of applicability to HACC sector Clients keen to participate in collaborative goal setting and value written information about their care plan Staff report a high degree of confidence re. goal setting, however audit demonstrates that practice is inconsistent, ongoing confusion re goals and actions, variable quality of documentation and lack of organisational systems in place to support effective GDCP. |
| **Phase 2 Capacity Building** | Develop a shared understanding of GDCP and its application across the EMR HACC sector Practical skill development for staff. | *Staff Education:* focussed on practical strategies to support GDCP<br>*Resource Development:* Draft toolkit developed including a range of person centred thinking tools and HACC based examples to support effective GDCP and GDCP template<br>*Evaluation:* Participant feedback collected regarding education and toolkit | Evaluation identified the education and toolkit relevant and appropriate for HACC staff. Importance of ongoing support and practice highlighted.<br>Identified the need for education and resources to support management regarding the organisational systems required for GDCP. |
| **Phase 3 Pilot** | Trial new practices and tools and review their impact on staff practice. | *Case Studies:* including submission of de-identified care plans using existing organisational templates (x 2) and new GDCP template (x 1) and reflective questionnaires. | Overall, staff reported tools as valuable to support GDCP. Practice audit demonstrated significant improvement in the quality of care plans (compared to Phase 1). Case studies using new GDCP of highest quality. |

**Revision of GDCP Toolkit, project evaluation and reporting.** Further information, including project report is available at: http://www.iepcp.org.au/active-service-model-emr-hacc-alliance

# Appendix 2: GDCP examples using the GDCP template

Included on the following pages are 3 examples of care plans documented using the GDCP template.

These examples include careplans created in a range of service types, namely:

- Local Government (HACC Assessment Service)
- Planned Activity Group
- Community Health (Diabetes Education)

We encourage agencies to utilise these as examples of good practice. They can be shared with staff and used as the basis of a team discussion about your care planning processes. You can then look at how to integrate elements of this approach into your own tools and documentation.

| Name: | Joan Farmer | Date Care Plan Developed: | 01/05/12 |
|---|---|---|---|
| People Involved: | Joan, Daughters Karen and Mary, Kate (Assessment Officer, Shire of Helpfulness) | Date for Review: | 01/07/12 |

**What do you want to achieve by working together?**

I want to continue living in my home

| Current situation | Goal | Actions | Person responsible | Timeframe | Completed | Outcomes |
|---|---|---|---|---|---|---|
| Joan's fatigue and breathlessness make cooking, cleaning and shopping very difficult.<br>Joan often eats toast for lunch and dinner as she is too tired to cook.<br>Joan is now heavily reliant on her daughters Karen and Mary. Daughters feeling exhausted and Joan concerned about becoming a burden on them | Reduce Joan's reliance on her daughters by introducing supports to assist Joan with cleaning, shopping and meal preparation | Initiate fortnightly home help to attend to heavy housework (vacuuming, bathrooms, hanging out washing) | Kate | 1/6/12 | | |
| | | Family to develop roster to provide meals 3 days a week (Fri - Sun) | Karen | 1/5/12 | | |
| | | Commence Meals on Wheels 4 days a week (Mon - Thurs) | Kate | 7/5/12 | | |
| | | Family to assist Joan with weekly grocery shopping | Mary | Ongoing | | |
| | Build Joan's confidence and provide strategies to ensure safety at home | Referral for OT assessment to review home setup and provide education and strategies to promote Joan's independence and safety in light meal preparation and housework (dusting, washing dishes, hand washing) | Kate | 5/5/12 | | |

| Care plan provided to: | | Client | Yes / No | |
|---|---|---|---|---|
| Family / Carer | Yes / No | Name/s: | Daughters Karen and Mary | Client Consent: Yes / No |
| Other Staff | Yes / No | Name/s: | Home Help Staff | Client Consent: Yes / No |
| Other Services | Yes / No | Name/s: | OT, Helpfulness Community Health Service (sent with referral), GP | Client Consent: Yes / No |

**Client Acknowledgement:** I understand and agree to this care plan **Client:** J Farmer **and/or Carer:**

| Name: | Joan Farmer | Date Care Plan Developed: | 05/06/12 |
|---|---|---|---|
| People Involved: | Joan, Daughter Mary, Kate (Coordinator, Happytown PAG) | Date for Review: | 01/08/12 |

**What do you want to achieve by working together?**

I want to make some new friends

| Current situation | Goal | Actions | Person responsible | Timeframe | Completed | Outcomes |
|---|---|---|---|---|---|---|
| Joan has become isolated at home after the recent death of her husband. She spends weekdays at home alone while her family are at work.<br>Daughter Mary is concerned about Joan's safety at home alone during the day.<br>Joan enjoys Bingo, & watching game shows. She used to enjoy baking, but hasn't cooked since she moved in with her family this year. | Enable Joan to meet new people and socialise while her family are at work | Attend Day Program at Happy-town each Tuesday 10am - 3pm | Kate | 1/7/12 | | |
| | | Encourage Joan to participate in the group's games program and cooking activities while attending the program | PAG team | Ongoing | | |
| | | Initiate referral to Helpful Harry Driving Service for volunteer driver to assist Joan travel to and from the group | Kate | 3/5/12 | | |
| | | Family to assist Joan with transport until Volunteer transport can commence (approx. 4 weeks) | Mary | 1st 4 weeks | | |
| | Build Joan's confidence cooking at home | Joan and Mary to start baking together on weekends and consider the need for an OT assessment (declined at present) | Joan / Mary | Ongoing | | |
| | Ensure Joan's safety at home and identify additional relevant supports | Referral for HAS assessment from local council and seek additional support to ensure Joan's health and wellbeing. | Kate | 5/5/12 | | |

| Care plan provided to: | | Client | Yes / No | |
|---|---|---|---|---|
| Family / Carer | Yes / No | Name/s: | Daughter Mary | Client Consent: Yes / No |
| Other Staff | Yes / No | Name/s: | Happytown PAG staff and volunteers | Client Consent: Yes / No |
| Other Services | Yes / No | Name/s: | Happytown council (sent with referral) | Client Consent: Yes / No |

**Client Acknowledgement:** I understand and agree to this care plan **Client:** J Farmer **and/or Carer:**

| Name: | Joan Farmer | Date Care Plan Developed: | 1/05/12 |
|---|---|---|---|
| People Involved: | Joan, Daughter Karen, Kate (Diabetes Educator) | Date for Review: | 22/05/12 |

**What do you want to achieve by working together?**

I want to understand and manage my Diabetes

| Current situation | Goal | Actions | Person responsible | Timeframe | Completed | Outcomes |
|---|---|---|---|---|---|---|
| My doctor recently told me I have Type 2 Diabetes and I feel anxious and confused about how to manage it.<br>I need some more information and ideas about how I can lose weight and prevent my health deteriorating. | Understand my Diabetes and the lifestyle and diet changes that I need to improve my health | Provide education and resources to Joan regarding Type 2 Diabetes | Kate | 1/5/12 | | |
| | | Enrol in the group Diabetes Education program for ongoing education and support | Joan | Within 2 weeks | | |
| | | Liaise with GP to develop ongoing maintenance plan | Kate | 8/5/12 | | |
| | Feel confident to monitor my blood sugar levels at home | Provide education and equipment to assist Joan monitor and record her Blood Sugar Levels (BSL) | Kate | 1/5/12 | | |
| | | Develop a reminder chart at home for BSL monitoring | Joan / Karen | 3/5/12 | | |
| | Lose 15kgs to reduce risk of further complications associated with my diabetes | Referral to Dietician to assist Joan develop and implement a weight loss plan | Kate | 1/5/12 | | |

| Care plan provided to: | | Client | Yes / No | |
|---|---|---|---|---|
| Family / Carer | Yes / No | Name/s: | Daughter Mary | Client Consent: Yes / No |
| Other Staff | Yes / No | Name/s: | Sarah (Dietician) | Client Consent: Yes / No |
| Other Services | Yes / No | Name/s: | GP (Helena Helpful) | Client Consent: Yes / No |

**Client Acknowledgement:** I understand and agree to this care plan **Client:** J Farmer **and/or Carer:**

# Appendix 3: Examples of Audited Care Plans

Included on the following pages are 3 examples of care plans that have been evaluated using both of the GDCP care planning audit tools. These examples have been taken from real HACC case studies, however all identifiable information about both the client, and the service provider has been removed and replaced with fictitious information.

Each example includes:

- A copy of the completed care plan
- An annotated version of the completed care plan
  - Information regarding the care planning template is documented in yellow
  - Information regarding the content of the care plan is documented in blue.
- A completed audit tool for care planning templates (with advisory notes) and
- A completed audit tool for completed care plans (with advisory notes).

These examples can be used to assist staff familiarise themselves with the auditing process.

## EXAMPLE 1 'JULIE': Care Plan Example

| Wellness Care Plan: Happy Valley Council | | | | | |
|---|---|---|---|---|---|
| **Client Name:** Julie Johnson | | **Plan Created:** 27/11/11 | **Assessor:** Wayne Wonders | | |
| **Stated Goal** (in client's own words) | **Agreed Goals** (SMART – specific, measurable, achievable, realistic and timely) | **Intervention / Action** (realistic) | **Responsibility** (who is doing it) | **Measurable outcomes** (how will we know this goal is achieved) | **Review / Discharge date** |
| Like to have dreams and fulfil dreams before husband passed away. Client would like to visit Greece again before she dies | Assist client to achieve her goals | 1.5hrs pf H/C | Council | | Review 2 months |
| | | H/M when req. | Council | | |
| | | Half price taxi | Taxi Directorate | | |
| | | MEPACS | PAV | | |
| | | Podiatry | Community Health | | |
| | | Fan to be given to client | Council | | |
| Sometimes I would like to go out | | Private gardener / son maintaining garden | Private gardener / son | | |

## EXAMPLE 1 'JULIE': Annotated Care Plan

**Wellness Care Plan: Happy Valley Council**

**Client Name:** Julie Johnson | **Plan Created:** 27/11/11 | **Assessor:** Wayne Wonders

| Stated Goal (in client's own words) | Agreed Goals (SMART – specific, measurable, achievable, realistic and timely) | Intervention / Action (realistic) | Responsibility (who is doing it) | Measurable outcomes (how will we know this goal is achieved) | Review / Discharge date |
|---|---|---|---|---|---|
| Like to have dreams and fulfil dreams before husband passes away. Client would like to visit Greece again before she dies | Assist client to achieve her goals | 1.5hrs pf H/C | Council | | Review 2 months |
| | | H/M when req. | Council | | |
| | | Half price taxi | Taxi Directorate | | |
| | | MEPACS | PAV | | |
| | | Podiatry | Community Health | | |
| | | Fan to be given to client | Council | | |
| Sometimes I would like to go out | | Private gardener / son maintaining garden | Private gardener / son | | |

Considering the client's goals are very broad, it would have been useful to break these down into tangible goals (as per the column heading).

Need to be careful about using acronyms / jargon.

This column could include information about what Julie will be doing / feeling / achieving if the action is successful in supporting her to achieve her goals

Timelines should be set for completing each action individually.

It would be more valuable to include a separate space on the template to document a date for a review of the entire care plan

There are no clear links between the goals that have been identified and the actions listed. Anyone who was not involved in the development of this care plan, could not easily understand why these actions have been chosen to support Julie 'fulfil her dreams', 'go to Greece' and 'sometimes go out'.

Additionally, many of these actions are quite vague. Is a referral being made for podiatry, has the client been provided with information so they can make contact independently or is the client already engaged with a Podiatrist at the Community Health Service?

A specific person / people should be allocated responsibility for each action.

For example, who is responsible for organising a Half Price Taxi Card?

It is also useful to include the actions that the client will be responsible for (in order to reinforce a collaborative approach).

This template does not allow space to document:

- Who was involved in developing the care plan
- A summary of the client's current situation
- Who the care plan has been provided to

## Audit Tool for Care Planning Templates: EXAMPLE 1 'JULIE'

| Audit Criteria | Scale | Notes |
|---|---|---|
| **The care planning template provides clear space to document:** | | |
| 1. The date of development of the care plan | (1 – Yes) 0 – No | *Space Provided* |
| 2. The people involved in the development of the care plan | 1 – Yes (0 – No) | *No allocated space* |
| 3. The client's current context / current situation | 1 – Yes (0 – No) | *No allocated space* |
| 4. The client's goals (what the client hopes to achieve) | (1 – Yes) 0 – No | *Space Provided* |
| 5. The actions required to achieve each goal | (1 – Yes) 0 – No | *Space Provided* |
| 6. The format makes it clear which actions relate to each goal | (1 – Yes) 0 – No | *The column format allows staff to align their goals and actions clearly* |
| 7. The person / people responsible for implementing each action | (1 – Yes) 0 – No | *Space Provided* |
| 8. The date / timeframe within which each action will be completed | (1 – Yes) 0 – No | *Space Provided* |
| 9. Who the care plan will be (or has been) provided to | 1 – Yes (0 – No) | *No allocated space* |
| 10. A date when the care plan will be reviewed | 1 – Yes (0 – No) | *The last column identifies a review date, but this format suggests that this relates to a review of each action. This should be separate from a review of the entire care plan.* |
| 11. Client Acknowledgement | 1 – Yes (0 – No) | *No allocated space* |
| **TOTAL** | **6 / 11** | *The audit has identified that this care planning template could be improved by: including space to document who was involved in the development of the care plan, the client's current context, who the care plan was provided to, when the care plan will be reviewed and evidence that the client has contributed to, and agrees to the care plan.* |

## Audit Tool for Completed Care Plans: EXAMPLE 1 'JULIE'

| Audit criteria | Scale | Notes |
|---|---|---|
| 1. The client has a documented care plan | **1 – Yes**<br>0 – No | |
| 2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented. | 1 – Yes<br>0 – No<br>**0 – N/A** | |
| 3. The date that the care plan was completed is recorded | **1 – Yes**<br>0 – No | |
| 4. The people involved in the development of the care plan are recorded | 1 – Yes<br>**0 – No** | *The client and the assessor are named on the care plan but it is unclear if anyone else contributed to the care plan.* |
| 5. The writing in the care plan is legible | **1 – Yes**<br>0 – No | |
| 6. The language used in the care plan is appropriate to the client | 1 – Yes<br>**0 – No** | *The clinician has used acronyms such as HC, HM and MEPACS on the care plan. It is unlikely that Julie or her family (and perhaps other service providers) would be familiar with these terms.* |
| 7. The care plan provides an overview of the current context / current situation | 2 – Yes<br>1 – Somewhat<br>**0 – No** | *There is no information provided about the current context or situation for Julie.* |
| 8. The goals set clearly demonstrate what the client hopes to achieve | 2 – Always<br>**1 – Sometimes**<br>0 – Never | *The goals set are vague and it isn't clear exactly what Julie hopes to achieve.* |
| 9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There were actions recorded against each goal, however they do not outline the key steps that need to be completed in order to achieve Julie's goals.* |
| 10. There are appropriate timeframes recorded for when each action will be completed | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There are no timeframes set for most of the actions recorded.* |
| 11. The person / people responsible for implementing each action are documented | 2 – Always<br>**1 – Sometimes**<br>0 – Never | *The staff member has documented a range of services as being responsible for the completion of actions – the care plan should articulate specific people (or their roles) rather than the name of the organisation. Additionally, it is unclear who will be responsible for making the necessary referrals or initiating services (e.g. half price taxi, personal alarm and podiatry)* |

## Audit Tool for Completed Care Plans: EXAMPLE 1 'JULIE' (cont.)

| Audit criteria | Scale | Notes |
|---|---|---|
| 12. There is a clear link between the actions and goals that are documented | 2 – Always<br>1 – Sometimes<br>(0 – Never) | *There is no clear link between the goals and actions. This is exacerbated by the inclusion of very vague goals, so it is unclear how the actions related to the goals set.* |
| 13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals. | 2 – Always<br>1 – Sometimes<br>(0 – Never)<br>2 – NA | *There is evidence that other organisations are required to be involved to achieve the goals set in the care plan, but the care plan does not describe if / how those agencies were involved or that referrals were made to those agencies.* |
| 14. There is evidence that the care plan is individualised and client centred | 2 – Always<br>(1 – Sometimes)<br>0 – Never | *The goals set are clearly individualised to the client. It is not clear however, if the actions are individualised to the client as there is no indication of how they relate to the client's individualised goals.* |
| 15. A date or timeframe has been documented for when the whole care plan needs to be reviewed | 1 – Yes<br>(0 – No) | *Not documented* |
| 16. Client acknowledgement | 1 – Yes<br>(0 – No) | *The care plan provides no evidence that the client has been involved in, or approved, the care plan as being relevant to their needs and priorities* |
| 17. There is evidence that a copy of the care plan was provided or offered to the client | 1 – Yes<br>(0 – No) | *No evidence of client acknowledgement or provision of care plan documented* |
| 18. There is evidence that, where appropriate, the care plan has been shared with relevant people | 2 – Always<br>1 – Sometimes<br>(0 – Never)<br>2 – NA | *There is evidence that there are multiple agencies/people required to be involved in the client's care (Council, Community Health, PAV, private gardener, son), however there is no evidence that the care plan has been shared with any of those agencies.* |
| **TOTAL** | **6 / 26** | *The audit has identified that this care planning could be improved by:*<br>• *Including an overview of Julie's current situation and priorities*<br>• *Ensuring that the language is appropriate and relevant to the client*<br>• *Documenting who was involved in the care planning process and who the care plan is being provided to*<br>• *Breaking the goals down into specific issues so that it is clear what Julie wants to achieve. These goals should then be clearly aligned with relevant actions to demonstrate how the service will work with Julie to support her to achieve those goals*<br>• *Articulating clear timeframes for each action*<br>• *Describing how/when referrals to other services/professionals will be made and who is responsible for making those referrals.* |

## EXAMPLE 2 'JILL': Completed care plan

### Happy Valley Community Health Service: Client Care Plan

Name: Jill Johnson
Date of Birth: 20/10/30
Sex: F
UR Number: X123456789

**Participants in Care Planning Process**

Consumer: Yes ☐ No ☐

I (consumer name) Jill Johnson have participated in the development of this plan.

Consumer Signature: J Johnson Date: 14/12/11

Copy to consumer: Yes ☐ No ☐

**Details of Other Participants**

Team members contributing to the development of this plan e.g. GP, health/community care providers, substitute decision maker, carer, family members, friends.

| Name | Relationship to consumer | Contact phone number | Other relevant contact details | Care plan provided (yes / no) |
|---|---|---|---|---|
| Lisa Lucky | Occupational Therapist | 98765432 | | |
| | | | | |
| | | | | |

Review Date: Case Conference Yes ☐ No ☐

Consumer issue / problem: Education regarding usage of bed stick

Goal: Increase safety when client is using bed stick

Action/s to be taken:
OT provided education on safely using bed stick. OT to also send information regarding proper and safe way to use bed stick

Consumer issue / problem: Difficulty transferring from current lounge chair and bed

Goal: Increase independence (with compensation techniques) while completing lounge chair transfers

Action/s to be taken: OT to trial chair raisers to increase height of lounge chair and bed. This will assist client in completing transfers in a safe manner

Responsible individual/s or service/s:

- Client
- Carer/s
- OT
- Happy Home Aged Services
- DVA

| Proposed Start Date: | Review Date: | Issue resolved (date): |
|---|---|---|
| 14/12/2011 | 14/01/2012 | |

## EXAMPLE 2 'JILL': Annotated Care Plan

### Happy Valley Community Health Service: Client Care Plan

Name: Jill Johnson
Date of Birth: 20/10/30
Sex: F
UR Number: X123456789

**Participants in Care Planning Process**

Consumer: Yes ☐ No ☐

I (consumer name) Jill Johnson have participated in the development of this plan.

Consumer Signature: J Johnson Date: 14/12/11

Copy to consumer: Yes ☐ No ☐

**Details of Other Participants**

Team members contributing to the development of this plan e.g. GP, health/community care providers, substitute decision maker, carer, family members, friends.

| Name | Relationship to consumer | Contact phone number | Other relevant contact details | Care plan provided (yes / no) |
|---|---|---|---|---|
| Lisa Lucky | Occupational Therapist | 98765432 | | |
| | | | | |
| | | | | |

This layout provides a clear summary of who was involved in the development of the care plan

Review Date: Case Conference Yes ☐ No ☐

Consumer issue / problem: Education regarding usage of bed stick

Goal: Increase safety when client is using bed stick

Action/s to be taken:
OT provided education on safely using bed stick. OT to also send information regarding proper and safe way to use bed stick

In order to understand the relevance and importance of these issues for Jill, it would be useful to include a summary of the current situation / contextual information.

Using 'issue/problem' as a prompt, reinforces a deficit/problem based approach (rather than a strengths based approach)

Consumer issue / problem: Difficulty transferring from current lounge chair and bed

Goal: Increase independence (with compensation techniques) while completing lounge chair transfers

This template does not include any indication of the timeframe for the completion of each action

Action/s to be taken: OT to trial chair raisers to increase height of lounge chair and bed. This will assist client in completing transfers in a safe manner

Responsible individual/s or service/s:

- Client
- Carer/s
- OT
- Happy Home Aged Services
- DVA

This format does not demonstrate the role of each of these people / services in implementing the care plan. It would be more valuable to assign direct responsibility for the completion of each action

| Proposed Start Date: | Review Date: | Issue resolved (date): |
|---|---|---|
| 14/12/2011 | 14/01/2012 | |

## Audit Tool for Care Planning Templates: EXAMPLE 2 'JILL'

| Audit Criteria | Scale | Notes |
|---|---|---|
| **The care planning template provides clear space to document:** | | |
| 1. The date of development of the care plan | 1 – Yes<br>0 – No | *Space Provided* |
| 2. The people involved in the development of the care plan | 1 – Yes<br>0 – No | *Space Provided* |
| 3. The client's current context / current situation | 1 – Yes<br>0 – No | *Space Provided* |
| 4. The client's goals (what the client hopes to achieve) | 1 – Yes<br>0 – No | *Space Provided* |
| 5. The actions required to achieve each goal | 1 – Yes<br>0 – No | *Space Provided* |
| 6. The format makes it clear which actions relate to each goal | 1 – Yes<br>0 – No | *The format clearly demonstrates which actions relate to each goal* |
| 7. The person / people responsible for implementing each action | 1 – Yes<br>0 – No | *There is space to document who is responsible, however it is not clear which person/service is responsible for each action.* |
| 8. The date / timeframe within which each action will be completed | 1 – Yes<br>0 – No | *No allocated space* |
| 9. Who the care plan will be (or has been) provided to | 1 – Yes<br>0 – No | *Space Provided* |
| 10. A date for the review of the care plan | 1 – Yes<br>0 – No | *Space Provided* |
| 11. Client Acknowledgement | 1 – Yes<br>0 – No | *Space Provided* |
| **TOTAL** | **9 / 11** | *The audit has identified that this care planning template could be improved by including space to document dates/timeframes within which each action will be completed and by allocating responsibility for each action* |

## Audit Tool for Completed Care Plans: EXAMPLE 2 'JILL'

| Audit criteria | Scale | Notes |
|---|---|---|
| 1. The client has a documented care plan | **1 – Yes**<br>0 – No | |
| 2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented. | 1 – Yes<br>0 – No<br>**0 – N/A** | |
| 3. The date that the care plan was completed is recorded | **1 – Yes**<br>0 – No | |
| 4. The people involved in the development of the care are recorded | **1 – Yes**<br>0 – No | *The care plan provides the name, relationship and contact details of the people involved in developing the care plan.* |
| 5. The writing in the care plan is legible | **1 – Yes**<br>0 – No | |
| 6. The language used in the care plan is appropriate to the client | **1 – Yes**<br>0 – No | *The use of acronyms or jargon has been avoided in this care plan.* |
| 7. The care plan provides an overview of the current context / current situation | 2 – Yes<br>**1 – Somewhat**<br>0 – No | *The care plan does not include an overarching statement about Jill's situation (this would provide a broad overview, highlight her priorities and reinforce a strengths based approach to care planning). The template does include spaces to document 'consumer issue / problem' for each goal. For the first goal, the issue is documented as 'Education regarding use of bedstick'. This is not the issue for the client – this is an action.*<br>*For the second goal, the issue is documented as 'Difficulty transferring from the current lounge chair or bed'. This does describe the clinical issue, but it does not outline the impact of this issue on the client's life.* |
| 8. The goals set clearly demonstrate what the client hopes to achieve | 2 – Always<br>**1 – Sometimes**<br>0 – Never | *The goals are worded in a clinical manner and could be improved by describing how each goal relates to what Jill wants to achieve (e.g. 'be able to get on/off my lounge chair and bed safely without help from my carer').* |
| 9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals | **2 – Always**<br>1 – Sometimes<br>0 – Never | *There are actions recorded against each goal that provide a clear outline of how and why the clinician will support Jill* |
| 10. There are appropriate timeframes recorded for when each action will be completed | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There are no timeframes recorded against any of the actions.* |

| Audit criteria (continued) | Scale | Notes |
|---|---|---|
| 11. The person / people responsible for implementing each action are documented | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *A list of responsible individuals / services is included, however as this is not linked to individual actions, it is unclear who is responsible for each action.* |
| 12. There is a clear link between the actions and goals that are documented | **2 – Always**<br>1 – Sometimes<br>0 – Never | *The link between the actions and goals is clear.* |
| 13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals. | 2 – Always<br>1 – Sometimes<br>**0 – Never**<br>2 – N/A | *There is no evidence that other services are required to achieve the set goals, however two external agencies have been listed as 'responsible services'. It isn't clear that these agencies have been engaged in any way.* |
| 14. There is evidence that the care plan is individualised and client centred | **2 – Always**<br>1 – Sometimes<br>0 – Never | *The goals appear to be individualised to the client.* |
| 15. A date or timeframe has been documented for when the whole care plan needs to be reviewed | **1 – Yes**<br>0 – No | *The review date has been documented at the end of the care plan.* |
| 16. Client acknowledgement | **1 – Yes**<br>0 – No | *Jill has signed and dated the care plan, acknowledging that she 'participated in the development of the care plan'* |
| 17. There is evidence that a copy of the care plan was provided or offered to the client | 1 – Yes<br>**0 – No** | *This section was left incomplete* |
| 18. There is evidence that, where appropriate, the care plan has been shared with relevant people | 2 – Always<br>1 – Sometimes<br>**0 – Never**<br>2 – N/A | *There is evidence that there are other programs required to be involved in the client's care (DVA, Happy Home Aged Services) however there is no evidence that the care plan has been shared with any of those agencies. There is also a prompt to indicate whether a copy of the care plan has been provided to the client – this has been left incomplete.* |
| **TOTAL** | **15 / 26** | *The audit has identified that this care planning could be improved by:*<br>• *Describing the current context for the client*<br>• *Ensuring that each documented goal clearly outlines what the client hopes to achieve*<br>• *Allocating responsibility for the implementation of each action to a specific person and recording appropriate timeframes for completion*<br>• *Describing if/how other relevant services will be engaged*<br>• *Ensuring all sections of the care plan are completed* |

## EXAMPLE 3 'JOSEPH': Completed Care Plan

| Management Plan: Happy Valley Planned Activity Group | |
|---|---|
| Name: Joseph Johnson | Date: 14/12/11 |
| Date of Birth: 2/2/32 | |
| Main Diagnosis:<br>Arthritis<br>Hypertension (controlled) | |
| Identified problem/s:<br>Shoulder pain | |
| Difficulties associated with problems:<br>Reduced physical activities<br>Social isolation | |
| Solution / Goals:<br>To participate in well for life activities<br>To participate in Active Service Model<br>Social Interaction | |
| Evaluation / Progress:<br>Through progress notes / attendance / evaluation<br>Through observation of staff<br>Through verbal and community forum engagement | |
| Date of Next Review: 14/06/2012 | |
| Additional Service Referrals: | |
| Comments:<br><br>Trudy Terrific (Coordinator) 14/12/11 | |

## EXAMPLE 3 'JOSEPH': Completed Care Plan

| Management Plan: Happy Valley Planned Activity Group | |
|---|---|
| Name: Joseph Johnson | Date: 14/12/11 |
| Date of Birth: 2/2/32 | |
| Main Diagnosis:<br>Arthritis<br>Hypertension (controlled) | |
| Identified problem/s:<br>Shoulder pain | |
| Difficulties associated with problems:<br>Reduced physical activities<br>Social isolation | |
| Solution / Goals:<br>To participate in well for life activities<br>To participate in Active Service Model Social Interaction | |
| Evaluation / Progress:<br>Through progress notes / attendance / evaluation<br>Through observation of staff<br>Through verbal and community forum engagement | |
| Date of Next Review: 14/06/2012 | |
| Additional Service Referrals: | |
| Comments:<br><br>Trudy Terrific (Coordinator) 14/12/11 | |

Rather than listing diagnoses and problems, it would be valuable to use more positive headings that enable a more holistic presentation of Joseph's priorities and needs (e.g. Current Situation). This would provide more relevant information to inform the care plan and reinforce a person centred; strengths based approach to care planning.

It would be useful to separate out the goals from the solutions (actions) in order to ensure that both can documented clearly and that relevant timeframes and responsibilities can be assigned.

The Active Service Model and Well for Life are not actions – these are general approaches to care. Documented goals should specifically describe the way that service will be delivered to support Joseph (e.g. engagement in certain group activities to promote social interaction, a physiotherapy referral to address Joseph's shoulder pain?)

Rather than documenting strategies that will be used to collect information about Joseph's progress, it would be more valuable to document what changes you anticipate to see when the care plan is implemented (how will you know if it's successful).

This template does not allow space to document:

- Who was involved in developing the care plan
- Clear actions (what will be done to support Joseph)
- Who is responsible for actioning the care plan
- Who the care plan has been provided to
- A date / timeframe for the care plan to be reviewed

## Audit Tool for Care Planning Templates: EXAMPLE 3 'JOSEPH'

| Audit Criteria | Scale | Notes |
|---|---|---|
| **The care planning template provides clear space to document:** | | |
| 1. The date of development of the care plan | (1 – Yes) 0 – No | *Space Provided* |
| 2. The people involved in the development of the care plan | 1 – Yes (0 – No) | *No allocated space* |
| 3. The client's current context / current situation | (1 – Yes) 0 – No | *The template has space to document 'main diagnosis', 'Identified problems', and 'Difficulties associated with problems', however these do not provide an overview of Joseph's situation or why he is joining the Planned Activity Group.* |
| 4. The client's goals (what the client hopes to achieve) | (1 – Yes) 0 – No | *Space Provided* |
| 5. The actions required to achieve each goal | 1 – Yes (0 – No) | *No allocated space* |
| 6. The format makes it clear which actions relate to each goal | 1 – Yes (0 – No) | *The goals and 'solutions' are combined which does not encourage staff to document either correctly* |
| 7. The person / people responsible for implementing each action | 1 – Yes (0 – No) | *No allocated space* |
| 8. The date / timeframe within which each action will be completed | 1 – Yes (0 – No) | *Space Provided* |
| 9. Who the care plan will be (or has been) provided to | 1 – Yes (0 – No) | *No allocated space* |
| 10. A date for the review of the care plan | (1 – Yes) 0 – No | *Space Provided* |
| 11. Client Acknowledgement | 1 – Yes (0 – No) | *No allocated space* |
| **TOTAL** | **4 / 11** | *The audit has identified that this care planning template could be improved by including space to document who was involved in the development of the care plan and who copies of the care plan were provided to. It would also be beneficial to rework the template to include an overview of the client's current context, separate spaces for goals, actions and the associated timeframes and responsible people.* |

## Audit Tool for Completed Care Plans: EXAMPLE 3 'JOSEPH'

| Audit criteria | Scale | Notes |
|---|---|---|
| 1. The client has a documented care plan | **1 – Yes**<br>0 – No | |
| 2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented. | 1 – Yes<br>0 – No<br>**0 – N/A** | |
| 3. The date that the care plan was completed is recorded | **1 – Yes**<br>0 – No | |
| 4. The people involved in the development of the care are recorded | 1 – Yes<br>**0 – No** | *The client and the assessor are named on the care plan but it is unclear if anyone else contributed to the care plan.* |
| 5. The writing in the care plan is legible | **1 – Yes**<br>0 – No | |
| 6. The language used in the care plan is appropriate to the client | **1 – Yes**<br>0 – No | *The use of acronyms or jargon has been avoided in this care plan.* |
| 7. The care plan provides an overview of the current context / current situation | 2 – Yes<br>**1 – Somewhat**<br>0 – No | *The diagnosis / problems lists do not provide any indication of Joseph's current situation or his priorities in relation to joining the Planned Activity Group* |
| 8. The goals set clearly demonstrate what the client hopes to achieve | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *The goals do not relate to what Joseph hopes to achieve* |
| 9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *The documented 'solutions' are not actions that describe how Joseph will be supported to achieve his goals (or address the identified problems)* |
| 10. There are appropriate timeframes recorded for when each action will be completed | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There are no timeframes recorded.* |
| 11. The person / people responsible for implementing each action are documented | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There is no information documented as to who is responsible for each action.* |

## Audit Tool for Completed Care Plans: EXAMPLE 3 'JOSEPH' (cont.)

| Audit criteria (continued) | Scale | Notes |
|---|---|---|
| 12. There is a clear link between the actions and goals that are documented | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *Not enough information documented to understand the goals and actions* |
| 13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals. | 2 – Always<br>1 – Sometimes<br>0 – Never<br>**2 – N/A** | *The care plan does not describe the inclusion of any other services. While this may be due to the lack of clarity regarding Joseph's goals, given the existing information, there is no evidence to suggest that other organisations needed to be involved.* |
| 14. There is evidence that the care plan is individualised and client centred | 2 – Always<br>1 – Sometimes<br>**0 – Never** | *There is little evidence that the care plan is individualised to Joseph's life. The care plan shows no indication of strategies that will be used to engage Joseph or address his personal needs / goals.* |
| 15. A date or timeframe has been documented for when the whole care plan needs to be reviewed | **1 – Yes**<br>0 – No | *No allocated space* |
| 16. Client acknowledgement | **1 – Yes**<br>0 – No | *There is no space allocated to enable Joseph to acknowledge his involvement or approval of the agreed plan* |
| 17. There is evidence that a copy of the care plan was provided or offered to the client | 1 – Yes<br>**0 – No** | *No allocated space* |
| 18. There is evidence that, where appropriate, the care plan has been shared with relevant people | 2 – Always<br>1 – Sometimes<br>**0 – Never**<br>2 – N/A | *There is no evidence that copies of the care plan were provided to Joseph, his carers, other staff or stakeholders.* |
| **TOTAL** | **10 / 26** | *The audit has identified that this care planning could be improved by:*<br>• *Including a summary of Joseph's situation and his priorities (rather than a list of diagnoses and problems)*<br>• *Articulating who was involved in the care planning process and if/how information from the care plan was shared with relevant people*<br>• *Documenting clear goals that outlined what Joseph wanted to achieve*<br>• *Recording specific actions that would be taken to support Joseph to achieve his goals, along with assigned responsibility and timelines.* |

# Appendix 4: Quality standards relevant to GDCP

The following table provides a summary of quality standards in the Community Care Common Standards (CCCS) and the Victorian Service Coordination Continuous Improvement Framework (CIF 2012) that are specifically relevant to GDCP. The standards also include a broad range of other criteria that describe the systems, approaches and practices required to effectively embed GDCP. These include standards related to coordination of care, partnership development, evidence based interventions and robust organisational systems.

| Quality standards | Standard | Description |
|---|---|---|
| Community Care Common Standards (CCCS) | Standard 2 | ***Appropriate access and service delivery:*** *Each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative.*<br>Expected Outcome 2.2: Assessment. Each service user participates in an assessment appropriate to the complexity of their needs and with consideration of their cultural and linguistic diversity.<br>Expected Outcome 2.3: Care Plan Development and Delivery. Each service user and/or their representative, participates in the development of a care/service plan that is based on assessed needs and is provided with the care and/or services described in their plan.<br>Expected Outcome 2.4: Service User Reassessment. Each service user's needs are monitored and regularly reassessed taking into account any relevant program guidelines and in accordance with the complexity of the service user's needs. Each service user's' care/service plans are reviewed in consultation with them. |
| | Standard 3 | ***Service user rights and responsibilities:*** *Each service user (and/or their representative) is provided with information to assist them to make service choices and has the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected.*<br>Expected Outcome 3.1: Information Provision. Each service user, or prospective service user, is provided with information (initially and on an ongoing basis) in a format appropriate to their needs to assist them to make service choices and gain an understanding of the services available to them and their rights and responsibilities.:<br>Expected Outcome 3.5: Independence. The independence of service users is supported, fostered and encouraged. |
| 2012 Victorian Service Coordination Continuous Improvement Framework | Criterion 6 | ***There is substantial evidence that care / case planning has occurred with consumers and service providers participating in their care in accordance with the Victorian service coordination practice standards***<br>Criteria 6 of the Continuous Improvement Framework outlines 25 points of evidence relevant to care planning that are supported by information provided in Section 3.6 of the Victorian Service Coordination Practice Manual |

# Appendix 5: Framework for GDCP Evaluation

| | Practice | Staff Experience | Client and Carer Experience | Organisational Systems |
|---|---|---|---|---|
| **Purpose** | Evaluate the extent to which GDCP practices are being implemented.<br>Identify the strengths and weaknesses of GDCP practices to support the provision of effective, person centred care. | Understand the impact of GDCP on staff practice.<br>Identify areas for ongoing improvement and additional systems and supports required to assist staff to implement effective GDCP. | Understand the impact of GDCP for HACC clients and their carers.<br>Collect information about clients' perceptions and experience of GDCP practices. | Ensure that organisational systems and documentation aligns with the principles of GDCP and enables effective practice. |
| **Data Collection strategies** | *Observation, peer support and staff supervision.*<br>*Audit tool for completed care plans.* | *Collation of staff feedback.* | *Collation of relevant consumer feedback.* | *Checklist of Organisational Systems to support GDCP.*<br>*Audit tool for care planning templates.* |

Organisations should collate this information, in order to understand:

- the strengths of the current approach and areas requiring ongoing improvement
- priorities and quality improvement actions for the upcoming year

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