

What is a care plan?

Staff use many different terms to describe care plans. This often creates confusion and can make communication and information sharing difficult. While a range of plans may be developed to support a client, it can be useful to think about care plans in the following categories:

Shared Care Plan

A shared care plan is an overarching plan, designed to support the coordination of care across multiple programs, services and/or agencies. It provides the client and staff with an overview of how the team (including the client) will work together to achieve the client's goals. A shared care plan should be developed collaboratively with the client (often led by the client's key worker or a nominated representative of the team).

Who needs one?

Shared care plans are required when a client accesses support / services from multiple programs and/or services.

What do we need to document?

The Victorian HACC program recommends the use of the [Shared Support Plan SCTT](#) template to support consistent shared care planning.

Goal Directed Care Plan (GDCP)

A GDCP is designed as a tool for the client. It should contain a brief summary of the client's current situation, their goals and how you will work together, to achieve those goals (WHO is going to do WHAT, WHEN and WHY). Developing a GDCP can empower clients and carers to actively participate in making decisions about their care and encourage shared responsibility for achieving positive results. With consent, it should be shared with others involved in the person's care including their family, carers and staff (within and beyond your agency).

Care plans should be 'living documents' that are reviewed and updated regularly to ensure they remain relevant and useful.

Who needs one?

GDCP should be considered for all HACC clients. The number, nature and complexity of goals included on the GDCP is dependent on the individual.

What do we need to document?

The Victorian HACC program does not mandate the use of a specific care planning template, however the best practice guidelines (such as the [Victorian Service Coordination Practice Manual](#)) and quality standards require that the GDCP contain a number of key elements. Agencies should consider how these elements can be integrated into a tool that is practical and efficient, given the practice context. Refer to Chapter 3 of the EMR GDCP toolkit for further information.

Action Plan / Treatment Plan / Service Plan

An action plan is a tool for staff and should sit alongside the GDCP to provide staff with the additional information required to deliver care effectively in line with the client's goals. This includes the specific strategies, approaches or equipment that will be used to support the person, along with any relevant information about a client's functional status (e.g. need for mobility aids, vision, cognition etc.) or risk management.

Who needs one?

Action plans are created for many clients, to ensure that staff have all the information required to support the person effectively.

What do we need to document?

The information included in the action plan will be dependent on the type of services being delivered (refer to HACC program manual for any service specific documentation requirements). Agencies should ensure that information being documented in the action plan is relevant and aligns with the client's goals as outlined in their GDCP (and shared care plan as appropriate).

NB: In some circumstances, clients may also be asked to sign off on their service plan, where it outlines the specific roles and responsibilities of the client and staff. This should sit alongside their GDCP and does not need to include a repeat of the information included on the GDCP.

To embed care planning effectively, it is important to review all of your assessment and care planning documentation and minimise any duplication. Also, ensure that your organisation's policies and procedures provide clear guidelines about where information is documented.



Putting it into practice

To streamline your documentation, first consider what information is meaningful and relevant to your clients. This includes:

- A brief summary of the client's situation (the context for the care plan)
- WHY you are working together (the goals should describe what the client wants to achieve)
- WHO is going to do WHAT, WHEN to support the client achieve their goals (the actions)

This should be documented on the GDCP which can be used to track progress and guide ongoing monitoring and review.

Any additional information that the staff need in order to support the client effectively, should be documented separately (e.g. treatment plan / action plan).

Example 1: Ivan is attending a PAG

Ivan's GDCP should contain information about:

- WHY Ivan is attending the group (goals)

Ivan wants to spend time with other Croatian people his own age

- WHO is going to do WHAT, WHEN to support Ivan achieve his goals

Ivan will attend the Croatian Club on Tuesdays. His daughter Lana will drive Ivan to and from the club for the first 4 weeks until volunteer transport can be arranged

In order to support Ivan effectively, the PAG staff and volunteers will need additional information about his functional status (e.g. mobility, cognition, vision, hearing) and Ivan's likes and dislikes (e.g. interests, previous experience). This information is not particularly relevant for Ivan and should therefore be documented separately (e.g. on his action plan).

Example 2: A district nurse is providing wound care for Betty

Betty's GDCP should contain information about:

- WHY the nurse is working with Betty (the agreed goals)

Betty wants to heal her leg wound and rebuild her strength so that she can start walking to the shops again

- WHO is going to do WHAT, WHEN to support Betty achieve her goals

The district nurses will provide wound management 3 times a week and education about things that will promote wound healing. Betty will keep the wound clean and dry between visits and elevate her legs when resting. The nurse will refer Betty to a physiotherapist to provide advice about mobility and an exercise program.

In order to treat Betty's wound effectively, the nurses will need to document more specific clinical information such as the features of the wound (e.g. measurements, exudate, wound tracings), the treatment approach (e.g. debridement, exudate management, dressings) and other factors that may impact on the wound healing. While this information is essential to enable the nurses to provide care, it is unlikely that this information will be meaningful and relevant to Betty. It should therefore be documented separately (e.g. on a clinical treatment plan or specific wound care plan).

