Tips for documenting ACAT Support Plans

We know that staff are committed to working in person centred ways and constantly tailor their approach to match each client's priorities, strengths and abilities. Often though, staff report that translating this approach into creating meaningful support plans is challenging.

This resource provides tips for ACAT staff about how to document a support plan that can become a valuable tool for you and your clients. Further information is available in the *Goal Directed Care Planning Toolkit*.

First and foremost,
remember that a support plan is a tool for the client!

The support plan should be developed with the client (along with relevant family members, carers and other support people as appropriate). The client should be actively involved in making decisions about their support plan, building on their strengths and resources.

You do not need to record everything you know about the client. It is designed to provide a brief overview of the current situation (your starting point), what the client wants to achieve (their goals) and how you will work together to support them achieve those goals (the recommendations / actions).

The assessment summary and support plan are not intended to include all of the information that service providers need to deliver support effectively. More detailed information is included throughout the NSAF and available via My Aged Care (MAC).

With that in mind, remember to:

- Only include information that is meaningful and relevant to the client.
- Ensure that the support plan is legible and that the language is appropriate for the client (avoid jargon and acronyms).
- Encourage the client to use their support plan as a reminder to complete the actions they are responsible for, track progress and to communicate with others about how you are working together.

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Breaking it down

Staff feedback and audit results indicate that many staff have difficulty documenting the assessment summary and support plan in a person centred, strengths based way and differentiating between goals and actions/recommendations. Included below are some tips to assist you with each of these sections.

Assessment summary

ISBAR (Introduction, Situation, Background, Assessment, Recommendations) provides a useful framework to document the assessment summary.

To reinforce a person centred approach, the assessment summary should be personalised, meaningful and strengths based. To support this, it's useful to include:

- Who is the client? (Think broadly about who the person / family is as a whole, rather than just listing the challenges they're experiencing)
- What's important to them? (This provides insight into the person's values and motivation)
- What's happening in their life right now that's led them to have a comprehensive assessment? (Consider what has changed and what the triggers are for them to seek support now)

Using the client's words (e.g. key descriptors they use) can be a useful way to capture how the person is feeling and how they are managing. For example, the support plan could information like "Since my recent fall, I feel very nervous about going up and down the back stairs by myself", rather than "Unsafe at back access". Describing how the client feels, provides great context for the service providers to start a conversation with the client during their service specific assessments. It is also helpful to be able to reflect that back to the client when you conduct reviews in the future.

Concern

Within the 'My Goals & Recommended Supports' table, the 'Concern' is designed to record information about the context for each goal. This can be documented in first person (i.e. "I am" or third person (e.g. "Bob is"). To support a person centred approach, consider including information about the person's strengths and resources, what they've tried and what's working well (or has worked in the past).

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Goals

The goals should describe the specific outcomes that the client wants to achieve. This should be determined by what is important to the person. Goals should:

- Describe the specific outcome the person wants to achieve
- Be meaningful within the context of the person's life
- Be action oriented (I want to be, do, feel, maintain …)
- Be written in first or third person (Jenny wants, or I want. Avoid patient/client wants).

Recommended Services/Strategies

Within this section, document recommendations about actions that the client, carer and other informal support people can take to work towards their goals. The recommendations should clearly outline the agreed steps – who is doing what, when.

Also record information about any additional resources that may be useful for the client and a summary of available services or strategies that you've discussed with the client for future consideration.

When describing options that are not being actioned now (e.g. you've discussed a referral to a service that the client is not ready to access now, but may consider in the future), include a note about how they can access that support in the future.

Included on the following pages are excerpts of deidentified ACAT support plans. Examples have been provided about how concerns, goals and recommendations can be written in a person centred way.

Checking whether you have documented the right information

A useful way to review whether you have included the correct information in your support plan is to imagine another team member was going to conduct a review with the client. Ask yourself whether the support plan includes the relevant information for that person to initiate a meaningful conversation with the client about how you have been working together, the impact of your intervention and whether their needs are being met.

You can also assess your documentation more formally, using the 'Audit tool for Completed Care Plans' (refer to Chapter 5 of the *Goal Directed Care Planning Toolkit*).

Example 1: Archie

Provided below is an excerpt of a client's ACAT support plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a support plan (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

Original Support plan excerpt	
Concern	**Goal**
To have a clean living environment	to have fortnightly Domestic assistance
To able to leave home feeling a little isolated *There is no need to include 'what they would like' in the concern. Instead, describe the impact of the challenge (i.e. what's not working) and reference Archie's strengths, or the strategies he's using now to address this. The way the second concern is written is unclear. It's likely that wanting to "be able to leave home" and "feeling isolated are separate ideas.*	Archie to have in home respite which could include meal prep *'Having' services is an action (i.e. what you will do to address the issue). Goals should describe the specific outcome that Archie would like to achieve. Also, there is no clear link between the second concern and goal. Providing in home respite +/- meal prep is unlikely to address Archie's concern about wanting to be able to leave his home. More information is required to explain this properly.*
Recommended Services/Strategies Home Maintenance – Not Yet In Place Transition Care – Not Yet In Place No current other recommended activities	*This text is auto-populated. There is no indication of what Archie and his carer/s, family or support people could be doing to support his safety and independence etc.*

Another way to write this would be	
Concern	**Goal**
Archie is finding it difficult to clean his home while wearing a sling on his right arm. He and Betty share the light cleaning jobs which works well for them, but heavy cleaning really hurts his shoulder and back.	Archie wants to keep his home safe and clean, without exacerbating his shoulder and back pain.
Archie doesn't feel confident using sharp knives to chop vegetables. He is eating frozen meals regularly.	Archie wants to prepare nutritious meals for himself and Betty.
Archie is no longer able to drive and he's starting to feel trapped at home.	Archie wants to get out of the house regularly to interact with other people.
Recommended Services/Strategies Archie will make an appointment with his GP this week to talk about strategies to manage his pain. He will ask for a list of his current medications and why he is taking them. The local pharmacist can also assist Archie review his medications and provide advice. Fran will call Archie every Friday to organise a time for her and the kids to visit each weekend.	

Example 2: Ivan

Provided below is an excerpt of a client's ACAT support plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a support plan (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

Original Support plan excerpt	
Concern	**Goal**
Client has a number of serious health issues which require monitoring as well as care of his PICC line	Client will be able to access nursing support
Due to Ivan's breathlessness and leukaemia treatment, he fatigues	OT referral so Ivan can safely transfer in and out of the shower
These concerns don't provide enough information to describe what challenges Ivan is currently experiencing (or their context). The use of acronyms and jargon is not appropriate in the support plan. Use the client and carer's name throughout the plan to personalise it.	*Accessing services is an action. Goals should describe the outcome that Ivan wants to achieve (i.e. what will be different when these actions are implemented?). They should be action oriented and owned by an individual (i.e. the client or carer).*
Recommended Services/Strategies	
Home Care Package Level 4 - Domestic Assistance – In place Start Date 1/1/2018 Nursing – Not Yet in Place Allied Health and Therapy Services – Not Yet In Place Develop an emergency plan in case of fire, heat wave or flood No current other recommended activities	*There is no context in the assessment summary (not included in excerpt) or here, that describes what an emergency care plan is, or why this is relevant to Ivan*

Another way to write this would be	
Concern	**Goal**
Ivan is keen to continue living independently in his own home. He requires assistance to dress his wounds, manage his catheter and monitor his health.	Ivan will manage his health conditions so that he can remain as independent as possible at home.
Ivan gets very tired and breathless while he's getting showered and dressed. He takes regular rest breaks which helps him conserve his energy. Ivan is worried about slipping over when he gets in and out of the shower.	Ivan will feel safe getting in and out of the shower. Ivan will understand a range of ways to save energy during his showering and dressing routine.
Recommended Services/Strategies	
Home Care Package Level 4 - Domestic Assistance – In place Start Date 1/1/2018 Nursing – Not Yet in Place Allied Health and Therapy Services – Not Yet In Place Ivan will discuss the development of an emergency care plan with his family. The plan should describe how you will stay safe in case of a fire, heat wave or flood. More information about emergency plans is available at *https://www.redcross.org.au/prepare*	*Note: This text is autopopulated*

Example 3: Anita

Provided below is an excerpt of a client's ACAT support plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a support plan (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

Original Support plan excerpt	
Concern	**Goal**
Cognitive decline. Symptoms of depression evident.	Anita will have access to supports to assist with medications health care and community access
Carer stress + +	Attend social support for carer respite
These concerns are quite vague, so there's no indication of the impact of these concerns. The language is very deficits based and is unlikely to reflect how Anita or Denise would describe these challenges.	*The goals should describe what Anita and/or Denise want to achieve by accessing these services & supports. Accessing supports & services are the actions that will be taken.*

Recommended Services/Strategies

Home Care Package Level 3 – Not Yet In Place

Residential Respite High Care – Not Yet In Place

Nursing – Not Yet In Place

Social Support Individual – Not Yet In Place

Visit GP for mental health assessment

It would be helpful to include additional information that describes the purpose and potential benefits of a mental health assessment.

Actions should be added that describe the next steps that Anita and/or her carers, family or informal support network are going to take to support Anita achieve her goals.

Another way to write this would be	
Concern	**Goal**
Anita has difficulty remembering to take her medications and finds it confusing when she has lots of instructions to remember. Anita's sister, Denise has set up a calendar to help them remember appointments and visitors.	Anita wants to take her medications consistently, so she can stay out of hospital.
Denise is feeling very tired and worries about how long she'll be able to continue looking after Anita at home.	Denise would like some time to herself so she can rest and look after her own health.

Recommended Services/Strategies

Denise and Anita will go to Anita's GP next week to discuss their concerns about Anita's depression.

We discussed the option to have an Occupational Therapy (OT) assessment. An OT can provide advice about staying safe at home and recommendations about equipment or modifications to make it easier to get around the house. If you'd like to explore these options, call My Aged Care on 1800 200 422 to organise a review appointment

Jo will register Denise with My Aged Care, so that her needs can be discussed in more detail and additional support provided if the need arises.