Tips for documenting RAS 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 writing and documenting meaningful support plans is challenging.

This resource provides tips for RAS 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 home support 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 useful to describe how the person is feeling and how they are managing. This is particularly helpful to provide the context for service providers to start a conversation in their service specific assessments and to enable effective reviews in the future. 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. 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 supports can take to assist them working 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 useful), include a note about how they can access that support in the future (e.g.).

Included on the following pages are excerpts of deidentified RAS 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: Harold

Provided below is an excerpt of a client's RAS 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**
Harold his limited mobility; his wife Gertie is the carer, she does not drive. They would like assistance with transport to medical appointments. *There is no need to include 'what they would like' in the concern. Instead, include reference to their strengths, or the strategies they're using now to address this.*	Harold and his wife Gertie would like to have access to transport to attend medical appointments. *Accessing transport is an action (i.e. what you will do to address the issue). Goals need to describe the outcome that Harold or Gertie would like to achieve.*

Recommended Services/Strategies

Transport - In place Start Date 31/10/2018

Develop an emergency care plan

Develop a personal emergency care plan in case of fire, heat wave or flood

Register and screen the carer's needs

No current other recommended activities

These actions do not provide a clear indication of who is doing what next. There is no context in the assessment summary (not included in excerpt) or here, that describes why these actions are relevant and how they will support Harold and Gertie.

Another way to write this would be	
Concern	**Goal**
Harold and Gertie no longer drive. They currently rely on their daughter to drive them to medical appointments but they feel like it's too much to ask during work hours. Gertie is concerned about the cost of taxis.	Gertie would like to be able to travel to Harold's medical appointments safely, without being a burden on their children.

Recommended Services/Strategies

Gertie will speak to their local doctor about completing an application for a half price taxi card at their next appointment (in 1-2 weeks).

Harold and Gertie to discuss the development of an emergency care plan with their children. 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*

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

Transport - In place Start Date 31/10/2018

No current other recommended activities

Note: This text is autopopulated

Example 2: Beryl

Provided below is an excerpt of a client's RAS 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**
Not coping heavy domestic duties. OA back, LL and hands. Pain + +	Clean house
Meal prep *These concerns don't provide enough information to describe what challenges Beryl is currently experiencing (or their context). The use of acronyms and jargon is not appropriate in the support plan*	Delivered meals *Goals should describe the outcome that Beryl wants to achieve. They should be action oriented and owned by an individual.*
Recommended Services/Strategies Domestic Assistance – In place Start Date 1/12/2018 Delivered Meals – Not yet in place No current other recommended activities	

Another way to write this would be	
Concern	**Goal**
Beryl is keen to continue living at home but is finding it increasingly difficult to look after the house. Vacuuming, mopping and scrubbing the bathrooms makes her joints ache so much that she needs to rest for a couple of days.	I will keep my home safe and clean, without exacerbating my joint pain.
Beryl enjoys cooking but finds it difficult to chop tough vegetables and carry heavy pans. Beryl saw an OT last year, who gave her some helpful tips and aids – when she remembers to use these, they really help. Sometimes she feels too tired to cook a whole meal for herself. Occasionally she buys frozen meals at the supermarket for days when she's too tired to cook.	I will eat nutritious meals every day to help me stay healthy and strong.
Recommended Services/Strategies Beryl will make an appointment with her GP this week to talk about strategies to manage her pain and ask for a list of her current medications and why she is taking them. The local pharmacist can also assist Beryl review her medications and provide advice. Beryl will practice using the kitchen aids that the OT provided last year to make cooking easier. Beryl will go to her daughter Anne's house for dinner every Sunday night. Anne will send Beryl home with 2 meals that she can heat up at home and enjoy during the week. Domestic Assistance – In place Start Date 1/12/2018 Delivered Meals – Not yet in place *Note: This text is autopopulated*	

Example 3: Jack

Provided below is an excerpt of a client's RAS 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**
Jack unsafe to attend gutters, heavy domestic management tasks *Very deficits based and the language is unlikely to reflect Jack would describe this challenge.*	Home maintenance – gutter cleaning *This is an action (what you will do). The goal should describe what Jack wants to achieve by accessing home maintenance.*
Recommended Services/Strategies Home Maintenance – Not yet in place No current other recommended activities	

Another way to write this would be	
Concern	**Goal**
Jack is managing well around the house, but no longer feels safe to climb the ladder to clean his gutters.	Jack wants to keep his house well maintained, including cleaning his gutters, without having to climb a ladder.
Recommended Services/Strategies 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. We also discussed physiotherapy and local exercise groups that could be helpful to stay strong and fit. If you'd like to explore these options, call My Aged Care on 1800 200 422 to organise a review appointment Home Maintenance – Not yet in place No current other recommended activities *Note: This text is autopopulated*	