GETTING STARTED WITH CARE PLANNING

Wimmera Primary Care Partnership

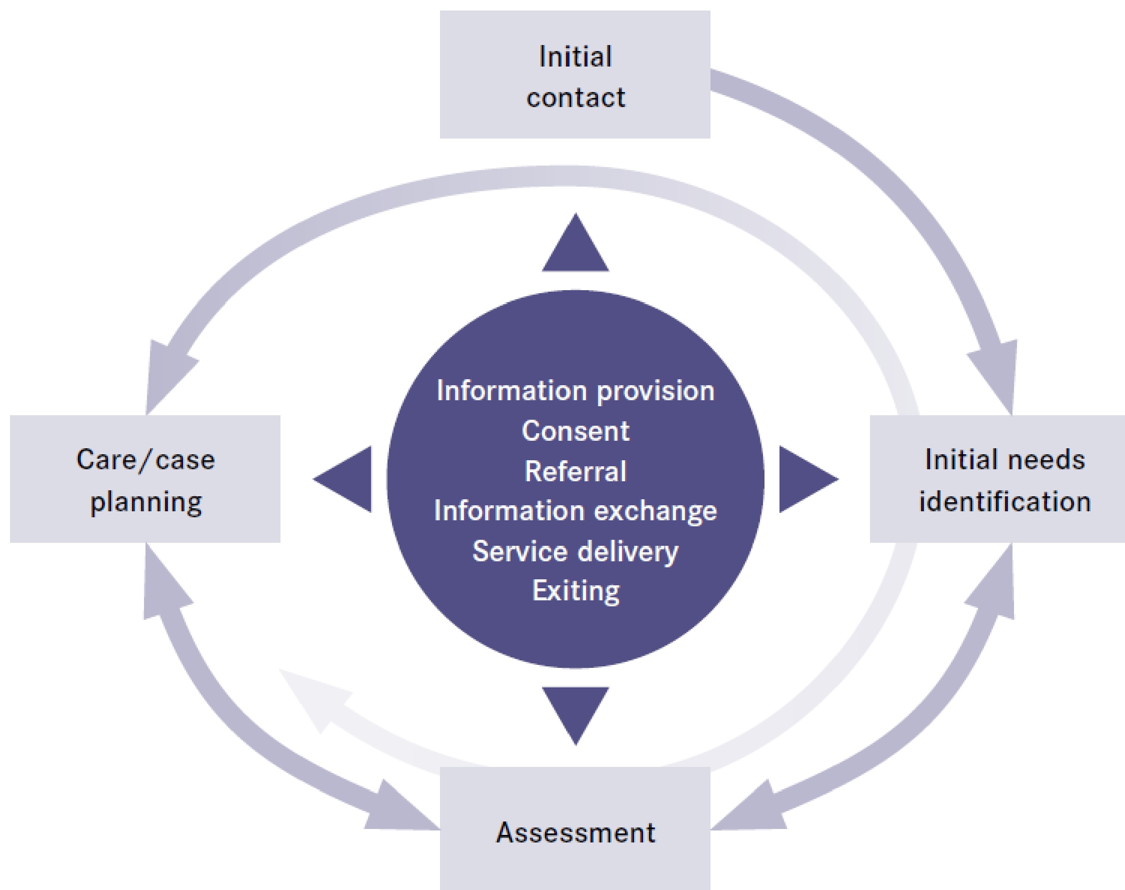
Objectives

- To demystify Care Planning
- To increase understanding of Care Planning and where it fits into practice – what is it?
- Why on earth do we do it!!
- To introduce the types of care plans
- Who should have one
- What does it look like when its done well

A little bit of context…

- Service Coordination
  - Victorian Statewide approach
  - Places consumer at the centre of service delivery
  - How do they get to you (Initial Contact – phone, web, front desk)
  - What is it that they need? (Initial Needs Identification – how do you work this out, questions, already done with referral)
  - Assessment
  - Care Planning

Figure 2: Service coordination elements



Resources

- Victorian Service Coordination practice manual
- Good Practice Guide
- Continuous Improvement Framework
- SCTT tools
- All available on Department of Health website
- https://www2.health.vic.gov.au/primary-and-community-health/primary-care/integrated-care/service-coordination/

What is a care plan?

- Client (and or carer) and health care professional:
  - negotiate and discuss what it is the client wants to achieve for their health
  - defines goals and strategies and then
  - identifies services/tasks to meet these goals

I want to be able to walk without my walking stick by Christmas

What is your experience ?

- On a scale of 1 to 10, please indicate your level of experience in developing care plans with clients?

1______________________________________10

No Experience — a lot of Experience

This is not a test!!!!

Your confidence in care planning

- On a scale of 1 to 10, please indicate your level of **confidence** in developing care plans with clients?

1____10

No Confidence	a lot of confidence

Types of Care Plans

- Service Specific: action/treatment/Service plan
- Intra-agency: shared within your agency
- Inter-agency: shared between agencies

Service specific care plan

- This is a care plan developed by a single service
- The consumer has one or more issues that can be managed with support of a single program area
  - Physiotherapy treatment plan
  - GP Asthma management plan

Intra-agency Care Plan

- Require multiple services from a single organisation
- Individual service specific care plans
- Overarching intra-agency care plan
- Requires Key Worker eg.
  - HARP Complex Care plan (example)
  - HACC services plan

COMMUNITY CARE PLAN

Wimmera Health Care Group

Participants in Care Plan Development:
Client Mr Jones
Wife Mrs Jones
Care Coordinator Mandy

Name: ....
UR: ....
D.O.B. ..../.........../...........
Use client label if available

Date developed 31/ 10 /2014.......
Review dates: 7/11/2015. Init:____

______________ ....22/4./2015. Init:__________ ......27/7../20...15 .Init:__________

Client Name/Signature:............................ .... Clinician Name/Signature M.Jones......................................

Current Situation: 80 year old man living at home with his wife. Medical Hx - COPD, Heart Attack, Internal defibrillator. Recent frequent admissions for exacerbation COPD and cardiac failure.

Goal	Action Required	By Who	Target Date	Outcome	Evaluation/Effectiveness
Mr Jones would like to be able to breathe easier, avoid frequent hospital admissions and return to continuing interests such as gardening Mr & Mrs Jones would like to learn how to recognise exacerbations of COPD earlier and have a management plan for if/when they occur	Education provided on inhaler technique, symptom dairy and daily weighs Follow up appointment with Manse Medical post sleep study recently completed Education on use of CPAP machine which has been recommended by Dr Shalini	Mandy/Heather Mr Jones to attend Heather Macdonald	7.11.14 Nov '14 Nov '14	Recommendations and alterations made to inhaler therapy altered commenced on O2 concentrator	Mr Jones breathing and sleeping a lot better. Mobility and activity much improved 10.12.14
Mr & Mrs Jones would like education regarding signs & symptoms of cardiac failure and corresponding management plan	Given cardiac failure resources; education given re self recognition and self management of peripheral oedema Referral to repeat Pulmonary Rehab WHCG with Heather Macdonald Referral to next Chronic Heart Failure Group WHCG in March 2014	Mandy Mandy Mr Jones to attend	7.11.14 7.11.14 4.3.15	Completing symptom diary and daily weighs. Feeling much more confident in self management Completed CHF group 22.4.15	Weight has been stable for months, no sign of oedema, breathing and mobilising well; continues to fill out symptom diary and daily weigh. 21.7.15

Inter-agency Care Plan

- Consumer has a range of chronic, complex &/or multiple issues
- Involves separate agencies
- 3 or more ongoing service providers
- Key Worker
  - Complex Care Plan
  - Diabetes Management Plan (Diabetes Educator, Podiatrist, Dietitian & GP)
  - GP Team care arrangement
  - CAPS case management care plan (packages)

WHY? Benefits for consumers

- Encourages consumer involvement and self-management (consumer with you 15-30mins… they then have to manage on their own)
- Manages and monitors long term care
- Assists consumers to set goals
- Documents information ("I know what to do when I get home")
- Is proactive rather than reactive
- Can increase consumer awareness of services

WHCG Client – who gets to see the whole person?

Social Worker

OT

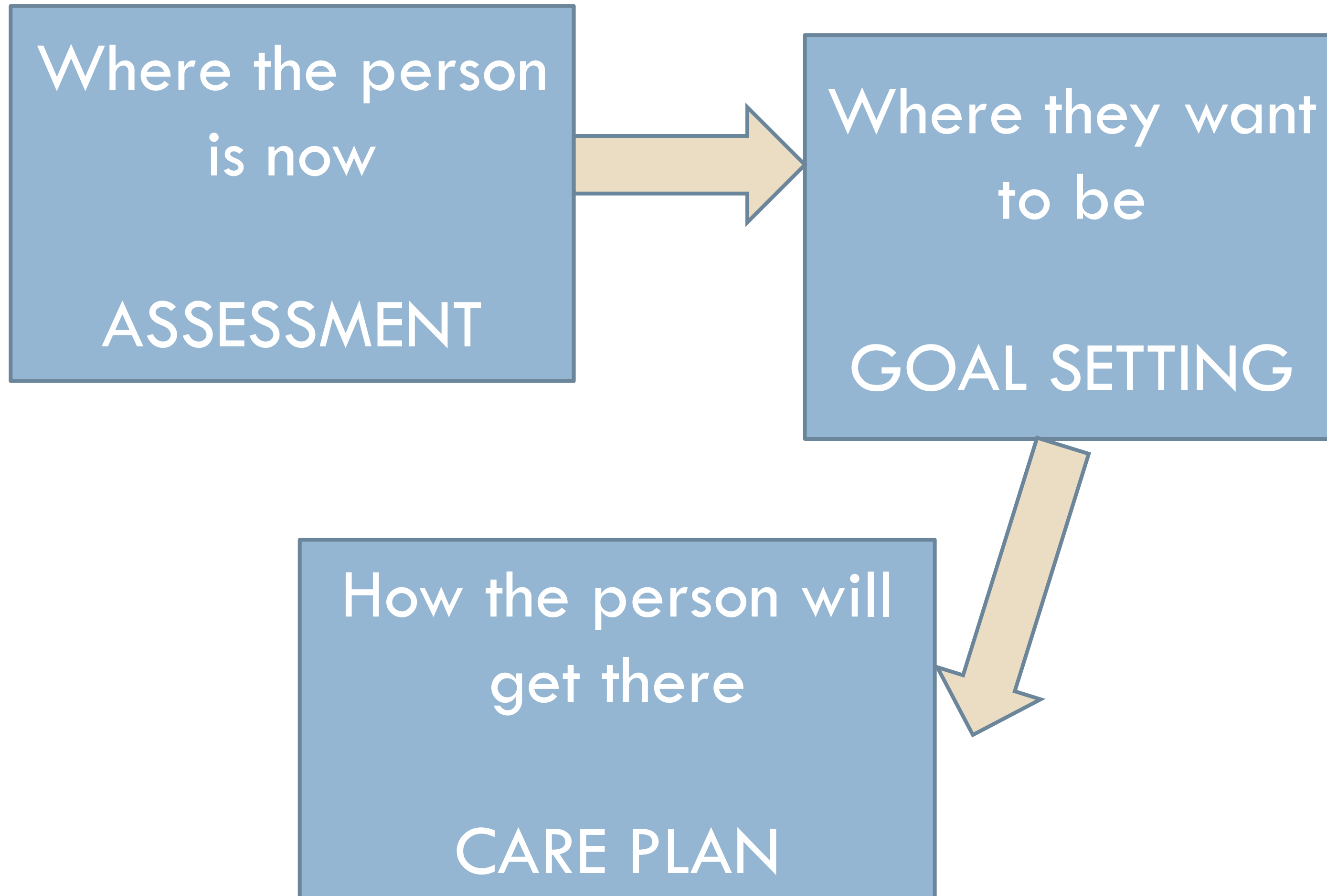
Physio

GP at Lister House

Person-Centred Practice Principles

- Partnership with health service
- Holistic
- Open communication
- Respect and privacy
- Inclusive of family and carers
- Supports self-management and responsibility
- Participation in decision making

Your job: helping people to get where they want to be

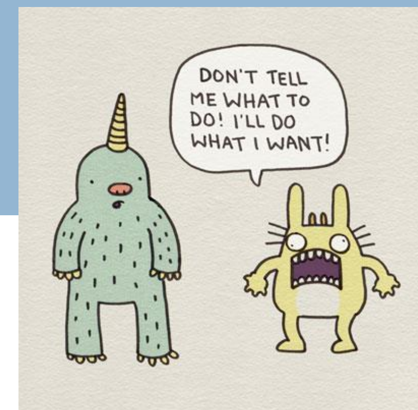


Care Plans – GOAL Setting

- Service Specific: action/treatment/Service plan
- Intra-agency Care Plan: shared within your agency
- Inter-agency Plan: shared between agencies

Goal directed

Consumer stated or agreed (not you telling them what you want them to do!!)



Who is the care plan for?

- The intended audience for the care plan might include the
  - Client
  - their family and
  - staff

  that are involved in the client's care.
- Care needs to be taken to use appropriate, inclusive language and avoid professional jargon or acronyms

- Referral for ACAS Ax
- Referral to HAS for HC and MOW
- WHCG OT to liaise with HACC
- Contact RDNS re wound management
- Physio management of HEP
- Physio/AHA to work with client
- COPD mgt: attend pulmonary rehab

"what does this mean Mum"…

I have no idea but the nurse said all these things would help me…."

Health Literacy

- http://www.bing.com/videos/search?q=youtube+ama+health+literacy+short+version&view=detail&mid=68D2C7E870804ED24DF268D2C7E870804ED24DF2&FORM=VIRE3

AMA Health Literacy Video - Short Version.mp4

Care plans – living document

- Reviewed and updated to remain relevant and useful
- Care plan should be considered for all clients – but not everyone requires one
- There is no mandated care plan template
- However, best practice standards indicate that they should contain a number of key elements

Elements of a Care Plan

1. Date care plan developed
2. Participants involved
3. Consumer stated issues
4. Consumer stated goals
5. Agreed actions & responsibilities
6. Timeframes
7. Review dates
8. Consumer acknowlegement
9. Actual review date

Audit the care plan - activity

1. Date care plan developed
2. Participants involved
3. Consumer stated issues
4. Consumer stated goals
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Coming back to goal setting…

- 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

Introducing Elsa….

- 60year old recovering from arthroscopy, torn cartilage
- grade 3/4 chrondroplasty, moderate arthritis knees, ankles
- Pain anterior
- Overweight
- Smoker
- Presents to WHCG Physiotherapy Department
- Does Elsa need a Care Plan? Assessment

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I want to be able to walk without my walking stick by Christmas

What is Elsa's care plan?

- Elsa and health care professional:
  - negotiate and discuss what it is the Elsa wants to achieve for her health
  - defines goals and strategies and then
  - identifies services/tasks to meet these goals

Elsa's Goal: I want to walk around the block without my walking stick in 3 months time

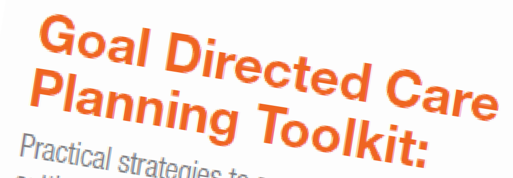
Elsa…and health professional

- Determine the actions to reach the goal:
- SMART GOALS
- **Specific**: Elsa will do her physio exercises and attend an appointment with a dietitian
- **Measurable**: Elsa does her exercises each day. Attends Dietitian appointment.
- **Realistic**: Exercises reduce pain so is motivation I need. Weight reduction will reduce pain also.
- **Timely**: Exercises in the morning when pain less.

Setting Goals…

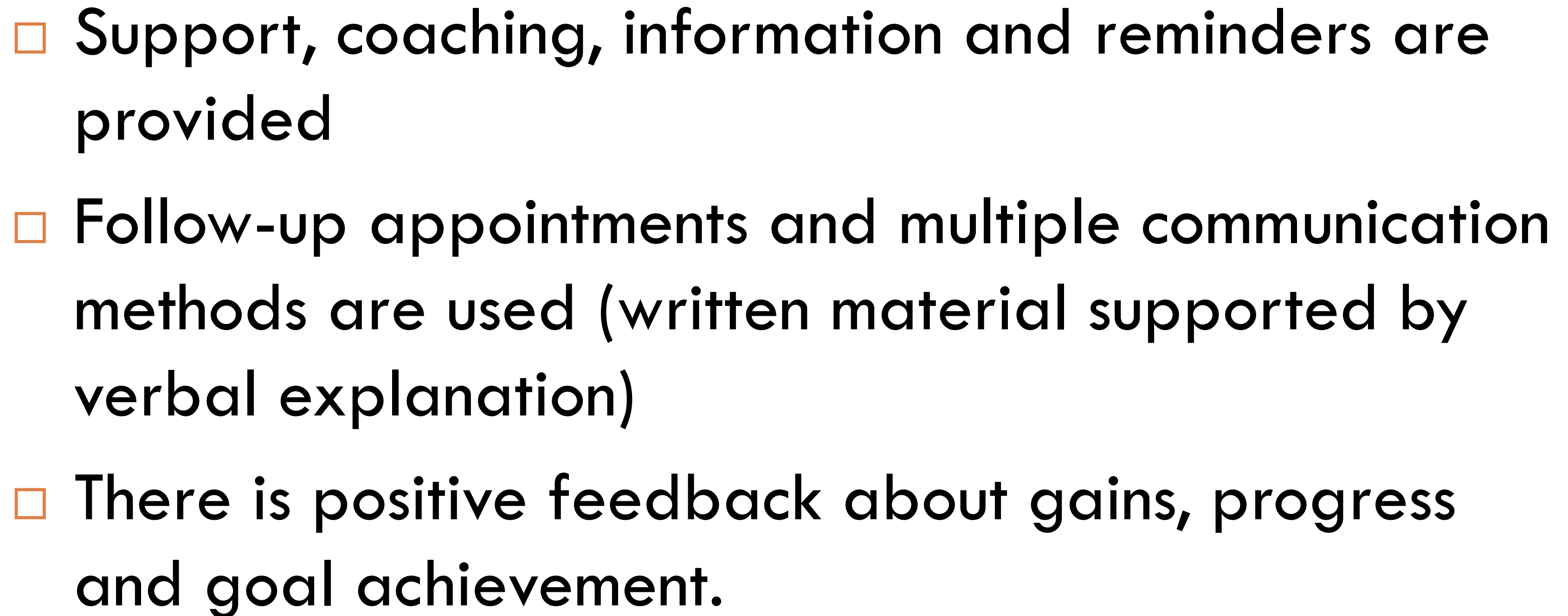
- Something the consumer wants to do
- Achievable
- Action Specific
  - What it is (walking, avoiding sugary drinks, smoking)
  - How much (walking the block, limiting soft drinks or replacing, cutting down smoking or stopping)
  - WHEN! Everyday, or weekdays, etc
  - How often?
- Confidence – scale of 1 to 10 how confident the client feels

resource



A person is more likely to follow care plan strategies if:

- There is shared understanding and respect for the person's goals and beliefs
- Goals are considered realistic and achievable by the person and support services
- Barriers to implementation are addressed through monitoring and problem solving



Support, coaching, information and reminders are provided
Follow-up appointments and multiple communication methods are used (written material supported by verbal explanation)
There is positive feedback about gains, progress and goal achievement.

WARNING!

- Multiple interventions, referrals, goals and timetables may be overwhelming
- Be careful not to set the person up for failure.
- Many people can only take so on much change and intervention in their lives at any one point

Motivational interviewing is a collaborative goal-oriented style of communication with particular attention to the language of change.

It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Miller & Rollnick (2012, p.29

example

- https://www.youtube.com/watch?v=dm-rJJPCuTE

Mr Fred Example

Male, age 72 years and lives in Hill Town. He lives alone and receives a pension. His GP referred him to Valley Health to see the dietician. The GP's referral letter and the Initial Needs Identification (INI) has revealed the following information about the client:

- Fred has newly diagnosed Type 2 diabetes.
- He is very overweight.
- He has trouble getting his shoes and socks on.
- He doesn't do much cooking, and only eats frozen food he heats in the microwave.