Australian Government

General Practice in Aged Care Incentive care planning template

Effective – August 2024

my medicare

Disclaimer

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Care planning

Care planning anticipates a patient's health care needs and provides a more preventive approach.

A typical care plan for an older person includes several parts, summarised in the figure below.

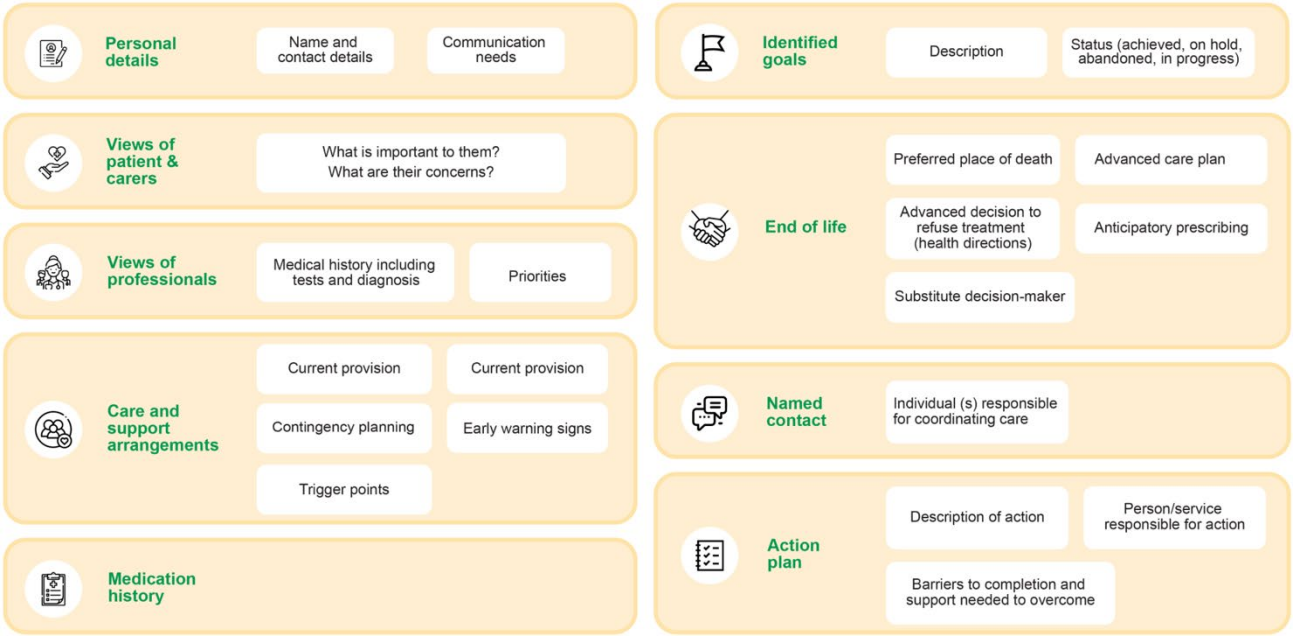

Figure 1: Care plan elements

When reviewing or contributing to a care plan, consider the elements above.

For example, planning may include:

- providing ranges of biomedical parameters (such as blood pressure ranges)
- sick day action plans
- monitoring requirements for medications or cycle-of-care elements for long-term conditions.

Care plans also provide guidance to other members of the care team in both the delivery of care and parameters for escalation or intervention if there is a change (including residential aged care home clinical staff, and other visiting primary care providers).

Care plan review/contribution

A care plan review/contribution template for residential aged care home residents is provided on the next page.

Review of care plan/care plan contribution for residential aged care home residents

Patient information:

Patient name:	
Date of birth:	
Medicare/Department of Veteran's Affairs (DVA) number:	
Substitute decision maker (where applicable):	
Residential aged care home/provider (RACH):	
Responsible GP:	
Date of care plan contribution:	

General information:

<table>
<tr><td rowspan="2">Health status and list of conditions/problems
Summary of health conditions and recent changes.
Medical history relevant to care plan.</td><td>List of medications
List all medications, including dosages and frequency.
Note any recent changes to medication regimen.</td></tr>
<tr><td>Allergies
Document any known allergies and reactions.</td></tr>
<tr><td colspan="2">Advanced care plan
Date of advanced care plan and summary of wishes.</td></tr>
</table>

Sources of information:

Comprehensive Medical Assessment (CMA) summary Date of last CMA and key findings and recommendations.
Multidisciplinary care plan from residential aged care provider Team members involved: List of all healthcare professionals involved in the patient's care (for example, GP, nurse, physiotherapist, pharmacist).
Contributions Summarise the contributions and input from each team member.
Action plan Detailed actions to be taken, including responsible team member and timeline for each action. Include specific interventions, treatments, and follow-up activities.
Coordination of care Describe how care activities will be coordinated among team members. Outline communication plan for updates and reviews.
Medication review (RMMR) **Medication management:** Summary of recent RMMR. Changes made to medications and reasons for changes. Plan for monitoring and follow-up.

Case Conferences

Date of last case conference

Participants: List of participants involved in the case conference.

Summary of discussion: Key points discussed. Decisions made and action items assigned.

Risk management and preventive care

Risk factors: Identify and document risk factors (for example, falls, infections, chronic conditions).

Preventive measures: Outline preventive measures and screenings (for example, vaccinations, regular check-ups).

Monitoring and review

Monitoring plan: Frequency of monitoring and specific health parameters to be tracked.

Review schedule: Dates for future reviews and updates to the care plan.

Follow-up appointments: Schedule for follow-up visits and reassessments.

Weight: Blood pressure:

Patient and family involvement

Engagement: Describe how the patient and their family are involved in care planning.

Feedback: Document any feedback from the patient and family regarding the care plan.

Additional notes

Other relevant information: Any other information relevant to the patient's care that has not been covered.

Individualised goals of care:

Patient's goals: Outline the patient's short-term and long-term health goals. Include patient's preferences and priorities for care based on what matters to them.

Health professional's goals: Describe the clinical goals set by the healthcare team.

Goal	How will it be achieved?	Who else will be involved?	How will it be monitored?	When will it be reviewed?

Signatures:

I have reviewed the care plan created by the [INSERT NAME] aged care provider/home and recommend the above.

GP signature:		Date:
Patient/Family signature (if applicable)		Date: