CARE PLANNING CHECKLIST

DEVELOPING PERSON-CENTRED AND GOAL ORIENTATED CARE PLANS

Developing a care plan which is **person-centred** and **outcomes focused** is critical to the success of implementing wellness and reablement and achieving high-quality outcomes for clients. Care planning involves working with your client to develop and document the approach to support the client achieve their goals. The care plan should outline the wellness and reablement strategies that the support worker will undertake with the client to help them maximise on outcomes that improve their overall wellbeing and maintain/regain their independence and autonomy.

This tool provides key principles and a checklist to support care coordinators/facilitators to develop person-centred and outcomes focused care plans with clients.

PRINCIPLES FOR EFFECTIVE CARE PLANNING

Although there is no standardised tool for effective care planning for wellness and reablement, there are certain principles that should underpin the process.

- Focus on the support your organisation can provide, not the service you deliver
- Focus on the outcome the client wants to achieve
- Keep your client's strengths at the heart of the care plan, focus on what they can do, not on what they can't
- Involve the client and their family/carer in the identification of appropriate wellness and reablement solutions and strategies
- Use wellness and reablement strategies that 'do with' and 'alongside', rather than 'do for' and 'to'
- Encourage clients to be involved in the decision-making process

- Clearly state what actions the client will undertake and what actions the support worker will undertake to support them
- Have appropriate mechanisms to review and realign strategies/approaches if a client's circumstances change
- Outline how, when and the frequency the support will be provided
- Have a clearly defined end date and plan for exiting support, especially for reablement-focused support
- The plan should be written clearly and easy to understand, free from jargon, and in the client's voice

GOAL-SETTING CHECKLIST

Does the care plan include/cover:

CLIENT CIRCUMSTANCES / SITUATION:

- ☐ information on the client's current situation/circumstance
- ☐ what is important and meaningful to the client
- ☐ the areas of wellness they wish to improve

GOALS:

- ☐ where the client wants to be/what they wish to achieve
- ☐ outline the steps for achieving their goals
- ☐ goals that have been developed using SMART principles
- ☐ the client's strengths, capabilities, and abilities

ACTIONS:

- ☐ the specific actions/strategies that will be undertaken during the support period
- ☐ who is responsible for completing the action (support worker, client and/or family member/carer)
- ☐ timeframe in which actions need to be completed

DATES/FREQUENCY

- ☐ how long the services will go for. When will they be reviewed/completed/finalised
- ☐ how frequently the support worker will visit/undertake actions

DOCUMENTING AND REVIEWING

- ☐ language is clear, concise, and easy to understand
- ☐ shared with the client, their family/carers
- ☐ review dates
- ☐ who the care plan will be shared with