Local Care Planning Roles and Responsibilities

Introduction and Context - Service Coordination and Care Planning

Partner Organisations of Campaspe Primary Care Partnership (PCP) have contributed and agreed to the Campaspe PCP 2009 – 2012 Strategic Plan and are committed to implementing the key priorities and objectives. Service Coordination is one of three priorities for the next three years. Embedded in the Service Coordination priority is the uptake of care planning practices by all partner organisations. Care planning is a major role in Service Coordination as it provides consumers with coordinated delivery of services; person centred care and reduces duplication of service provision (Victorian Service Coordination Practice Manual 2009).

What is a Care Plan?

A care plan is used when clients have complex or multiple needs and require services from more than three Service Providers. Care plans address consumer needs by encouraging a team approach, with the consumer at the centre of the care. It helps identify key issues, agreed goals and actions, responsible individuals/services and target dates for each goal (Victorian Service Coordination Practice Manual 2009).

Providers are encouraged to use the ***SCTT Care Coordination Plan*** **(Appendix 1)** as it provides a clear template to be able to include everything needed for a care plan. The use of the Care Coordination Plan can increase consumer and carer awareness of the support services available to them and promotes person-centred care practice by including them in decision making (Victorian Service Coordination Practice Manual 2009).

A consumer's care plan can be either Intra-agency or Inter-agency. An Intra-agency care plan is developed when a consumer only requires multiple services from the one agency. An Inter-agency care plan involves more than one organisation involved in the consumers care. A client with multiple or complex needs and requires more than three services from different agencies must have an Inter-agency care plan. Refer to **Appendix 2** for reference to various types of care plans.

Key Worker

In order for an effective Care Plan there needs to be a Key Worker assigned to each Care Plan. The Key worker needs to be a qualified staff member who has the skills and competencies to provide care coordination. The Key Worker is assigned at the first case conference. They do not have to be the person who coordinated the case conference; instead the key Worker is selected based on the consumer's preference, their rapport with the consumer and their frequency of contact (Victorian Service Coordination Practice Manual 2009).

Steps in Developing Care Plan

1. **Does the consumer require a care plan?**

   1.1. Do they receive more than 3 services?
   1.2. Do they have complex or multiple needs?

   If yes to either of these questions a care plan needs to be developed.
   Determine if they require an Inter-agency or Intra-agency care plan.

2. **The care plan and care plan process needs to be explained to the consumer.**

   2.1. The consumer needs to be aware of the advantages of having a care plan.
   2.2. Written documentation is given to the client such as ***Care Planning Information for Consumers*** **(Appendix 3)**

3. **Identify the participants in care and which participants need to be involved in the Care Planning process.**

   3.1. This is determined in discussion with the client. Participants can include family members, specialists, GP and allied health professionals. The client may wish to have an alternative decision maker involved in their care plan if they do not want to participate, prefer an advocate, require an interpreter or prefer family to be involved.
   3.2. Obtain consent to be able to share information with participants involved in the care plan. Use the ***Consumer Consent to Share Information*** **(Appendix 4)** form to obtain consent.

4. **Arrange and facilitate a care planning conference.**

   4.1. Invite all parties involved. Preferred option is for Service Providers to attend care planning conference but if this is not possible provide them with the option of sending in their feedback and goals on the care plan.
   4.2. Develop draft care plan with the consumer including the reason for the care plan, the consumer's health details and goals and circulate to Service Providers before the case conference to allow people time to think how the goals for their consumer may be met. Be sure to include contact details for all parties involved on the care plan.

5. **Develop Plan at care planning meeting.**

   5.1. Participants and client to identify key issues, agreed goals and actions, responsible individuals/services for each action and target date for each goal.
   5.2. Set review date for plan and record. Review must take place as closely as possible to the review date or earlier if necessary which is the responsibility of the Key Worker. Timeframe for review is dependent on each individual's needs and goals.

6. **Assign Key Worker**

   6.1. Key worker is to be selected based on the Consumers preference, relationship with the client, and frequency of contact.

6.2. Key Worker is responsible for updating care plan, facilitating case conferences, reviewing plan and circulating to all parties involved. See Roles and Responsibility of Key Worker below.

Roles and Responsibilities of the Key Worker

1. **To ensure the consumer understands and agrees to the care plan.**

   1.1. If appropriate to the organisation the consumer should sign off on the care plan.

2. **Ensuring the care plan is reviewed by the agreed date which can be earlier if required.**

   2.1. The timeframe for review will vary for each individual depending on their needs and actions.
   2.2. The review is to be facilitated by the Key Worker. The review can either be through a case conference, individually or a meeting.
   2.3. To utilise the ***Review of Care Plan*** template **(Appendix 4)** to record the progress of each goal.
   2.4. Once review has been completed disseminate to service Providers involved and client.

3. **Continually update the care plan.**

   3.1. All incoming correspondence from participants to be included.
   3.2. When new services are involved invite the Service Provider to contribute to the care plan.
   3.3. Each time the care plan is updated key worker is to provide a copy to everyone involved in the care plan including the consumer.

4. **Ensure the consumer understands their options regarding exiting the Care planning process and procedures.**

5. **To ensure the requirements of the Health Records Act and other privacy legislation are met.**

   5.1. Care plan to be circulated via connectingcare.com or Australia Post

6. **To continually engage and empower the consumer and where required act as an advocate** (Victorian Service Coordination Practice Manual 2009).

References:

Primary Care Partnerships (2009) Victorian Service Coordination Practice Manual 2009. A Statewide Primary Care Partnerships Initiative.

Campaspe Primary Care Partnerships (2009) Strategic Plan 2009-20012.

Care Coordination Plan

For consumers with complex and/or multiple issues, to support a coordinated approach. It shows who is involved in a consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Consumer Consent to Share Information

Before developing this plan, ensure consent to share information has been obtained using the 'Consumer Consent to Share Information' tool template.

Reason for Plan.

Participants in Care

List known persons currently contributing to the consumer's care, including the individual and the carer/advocate and the key worker /care plan coordinator/facilitator, (e.g. GP, health/community care providers, substitute decision maker, family members, volunteers or friends who provide assistance.) Append sheet to specify any additional persons.

Name	Role or area of support	Contact phone number/s	Other relevant contact details (e.g. agency, email)	Participant in planning process (yes/no)	Copy of plan provided (yes/no)
	Consumer				
	Carer				
	Key Worker				
	GP				

Supporting Documentation

This may include social profile, assessments, service plans, support plans, GP plans, advance care plans, emergency management plans, screening or risk alerts. List appropriate documents and source or location.

Produced by the Victorian Department of Human Services, 2009

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Care Coordination Plan

For consumers with complex and/or multiple issues, to support a coordinated approach. It shows who is involved in a consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Issues/problems (list in order of priority)	**Agreed goal** (measurable)	**Action/s** to be taken & **by whom**	**Target date**
1	**1.1**		
	1.2		
2	**2.1**		
	2.2		
3	**3.1**		
	3.2		
4	**4.1**		
	4.2		

Plan developed: / / Target Review date: / / Case Conference: ☐ Yes ☐ No

Consumer understands and agrees to this plan: ☐ Yes ☐ No

Signature if applicable: Date: / /

Append more sheets as necessary.

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Review of Care Coordination Plan

For use when the Care Coordination Plan is reviewed. It shows the outcomes/progress of agreed goals and planned actions

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Issue & Goal Reference (Refer to Care Coordination Plan):	**Progress**	**Source of information**

Review of Care Coordination Plan

Supporting Documentation

Review date: / / Case Conference: ☐ Yes ☐ No

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Appendix 2 Care Plan Definitions

Type of Care Plan	Definition	Tools	Examples
Service Specific Care Plan.	A service specific care plan developed by a ***Single service.*** • The consumer has one or more issues that can be managed with the support of a *single program area* ***Client services plan/treatment plan***	• Service specific treatment plan. • Specific program or service tools	***Client services plan/treatment plan*** • Consumer care plan • Individual treatment plan • Nursing care plan • GP management plan • Continence management plan
Intra-agency Care Plan	An intra agency care plan is used for consumers who ***require multiple services from within a single organisation,*** • Individual service specific plans and an overarching intra-agency care plan • Requires **Key worker.** ***Agency care plan***	• SCTT Care Coordination Plan • Agency developed plan	***Agency care plan*** • Multiple service plan <u>Key Worker</u> Each agency needs to develop own policy (refer to *Local Care Planning Roles and Responsibilities, Campaspe PCP* document)
Inter-agency Care Plan	The consumer has a range of chronic, complex &/or multiple issues that require the coordinated support of ***two or more separate agencies.*** • Team approach • More than 3 service providers • Requires **Key worker.** ***Complex care plan***	• SCTT Care Coordination Plan	***Complex care plan*** • GP Team Care Arrangements • Multidiscipline care plan • Case management meetings <u>Key worker</u> Requires inter agency policy/agreement (refer to *Local Care Planning Roles and Responsibilities, Campaspe PCP* document)

Components of a Care Plan - Consumer Outcomes and Good Practice Indicators	References
1. Date care plan developed 2. Participants in development of care plan 3. Consumer- stated and agreed issues or problems 4. Consumer – stated and agreed goals 5. Agreed actions and name of person or services responsible for each action 6. Timeframe for attaining goals and actions 7. Planned review date 8. Consumer acknowledgement signed or verbal. 9. Actual review date. *Pg 33 Victorian Service Coordination Practice Manual 2009*	• Victorian Service Coordination Practice Manual 2009 - PCP Victoria • Clinical Indicators in Community Health June 2009 - Victorian Healthcare Association. • Service Coordination & Integrated Chronic Disease Management 2010 survey, Department of Health, Victoria • Campaspe PCP Care Planning Key Worker Roles and Responsibilities (November 2010)

Care Coordination Planning Information

DRAFT Feb 2008

What is care planning?
Care planning is deciding what needs to be done for you to be **as healthy as possible**. You might do this together with others who are involved in your care, your '**care team**'.

Who is involved?
- you
- key worker or care plan coordinator - this could be you, your GP, a carer or a worker who will coordinate the plan and communicate with the care team.
- other people on your care team - people involved in assisting you to achieve your goals.

What is a care coordination plan?
This is the document which includes:
- who is involved in supporting you
- their contact information
- issues that effect your health
- important goals you want to achieve
- actions planned
- who is responsible for each action
- date for review

You can have a single care plan, which is developed between you and one other person. You might have more than one care plan. If you have many different issues and people involved, it helps to have a **care coordination plan.**

Why have a care coordination plan?
- It helps to remember what was planned and who is going to be involved.
- You can look back and see what has been achieved.
- If you choose, you can show it to other people involved in helping you.

What does a key worker do?
- work with you to develop a plan with realistic goals to support your health.
- assist you to monitor your progress.
- assist you to identify and address barriers that prevent you achieving your goals.
- communicate with the members of your care team and plan the review.

Who can I ask to start a plan?
You can ask a trusted family member or friend, your doctor, case manager, care coordinator, key worker, nurse, or another health worker who you trust to do this with you or help you find the best person.

What happens to the information?
You have a say in what happens to your information. Your information can only be seen by yourself and the people with whom you agree to share information, unless required by law such as in a medical emergency. This applies whether the information is written in paper files or entered into a secure electronic record on the computer (electronic care coordination plan). You can ask for a copy of your care coordination plan to be sent to others so that you don't have to repeat the information.

Electronic care coordination plan
This is where the plan is recorded on a computer system by your care providers, so that members of your care team can see it on their computer and it can be kept up to date as things change.

Department of Human Services

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The Place To Be

Consumer Consent to Share Information

To record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Section 1: Proposed Information Uses and Disclosures

Service Type Examples: – Physiotherapy – Specialist consultant	Name of Agency Examples: – Any agency – Nominated clinic	Type of Information *(including limits as applicable)* Examples: – All relevant information – Test results only	Purpose/s Examples: – Referral – Care coordination

Section 2: Record of Consumer Consent

2(a) Written Consumer Consent Or

The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers. I understand this and I give my informed consent for the information to be shared as detailed above.

Signed:

Dated: dd/mm/yyyy / /

Signed by:

☐ Consumer OR

☐ Authorised representative on behalf of:

(Consumer)

Witnessed by:

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

2(b) Verbal Consumer Consent

Worker/Practitioner Use Only

Verbal consent should only be used where it is not practicable to obtain written consent.

I have discussed with the consumer/consumer's authorised representative how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

Signed:

(Worker/Practitioner)

Dated: dd/mm/yyyy / /

Worker/Practitioner Name:

Position:

To ensure the consumer/consumer's authorised representative is able to make an informed decision about consent to the sharing of information as detailed above, the worker/practitioner should: (tick when completed)

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *'Your Information – It's Private'* ☐
4. Provide the consumer with a copy of this form if requested (see guidelines) once completed ☐

Produced by the Victorian Department of Human Services, 2009

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consumer Consent to Share Information