Dun Laoghaire Rathdown - Developing and Reviewing Care Plans

6.7 Developing a Care Plan

6.7.1 A care plan should be undertaken by the worker who completed the comprehensive assessment in collaboration with the service user. It should record as closely as possible the needs and goals of the service user as they have described them, though it may be necessary for the worker to discuss adapting the entries or service user plans. If discussion is required this should be done in the spirit of collaboration and shared work. Entries in the care plan should not be recorded without agreement of the service user. A list of situations where it may be useful to revise goals with the service user include:

6.7.1.1 Where the goals are very long term it may be useful for the worker to discuss breaking these into shorter term, more achievable goals. Note that the longer term goal should also be recorded.

6.7.1.2 If the service user does not wish to work with a particular agency, although they have a goal which necessitates such work, this should be discussed and a plan agreed as to how the desired outcomes can be met in a way which the service user supports. If the service user does not wish to engage or provide information this must be respected and alternative plans developed.

6.7.2 The steps to establishing a care plan are:

6.7.2.1 Entering the main issues and goals arising from the assessment into a care plan in order of priority according to the service user.

6.7.2.2 Written consent should be sought from the service user to share relevant information that the service user has given during the assessment process for the purpose of referral to required supports/ services.

6.7.2.3 Contacting other services involved in providing supports, these services may be engaged in the case already or may need to be engaged in the care plan. Agreement of involvement in the care plan can be done by phone or in an inter-agency care plan meeting.

6.7.3 In relation to each area of work the care plan requires the following fields to be completed:

6.7.3.1 Date

6.7.3.2 Goal/ Objective

6.7.3.3 Timescale

6.7.3.4 How will progress be measured

6.7.3.5 Action/ steps to be taken (Work to be done to achieve goal/ objective)

6.7.3.6 Person & organisation responsible for action

6.7.3.7 Outcome

6.7.3.8 Comment: (reasons achieved/not achieved). (See Appendix IV.)

6.7.4 All entries in the care plan should meet SMART criteria:

6.7.4.1 Specific: be as detailed as possible, i.e. rather than saying reduce drug use, state which drugs are being reduced and by how much.

6.7.4.2 Measurable: there will be a clear and (where possible) independent way of measuring whether an objective has been achieved.

6.7.4.3 Agreed: the goal should be agreed by the service user and the worker, ideally the service user will be supported to generate the care plan actions wherever possible.

6.7.4.4 Realistic: both the service user and the worker should take time to reality check goals. If goals are very ambitious it may be best to stagger large goals into more short term goals.
6.7.4.5 Timed: all actions should have a clear time frame.
6.7.5 Once the care plan is complete the actions should be progressed in regular one-to-one sessions. When a new action is identified this should be added to the care plan with inter-agency communications being undertaken as required.
6.7.6 If the service user has any problems with the plan or any of the services involved they should be encouraged to discuss this with their case manager at the earliest opportunity.
6.7.7 If the case manager or key worker is not able to effectively address issues that arise they should follow the DLR Gaps and Blocks procedure.
6.7.8 A formal care plan review should be undertaken every two months.

6.8 Conducting Care Plan Reviews
6.8.1 Reviews provide an opportunity to reflect on general progress. Formal care plan reviews provide an opportunity to re-evaluate the goals, progress and service inputs in a focused way. This can be done by phone or through a care plan meeting.
6.8.2 A review can provide an opportunity to brainstorm the reasons for lack of progress and what changes need to occur or what supports need to be put in place.
6.8.3 The review should include the following questions:
6.8.3.1 Have other agencies/key workers met their part of the care plan?
6.8.3.2 Has the case manager met their part of the care plan?
6.8.3.3 Has the service user met their part of the care plan?
6.8.3.4 What has been achieved?
6.8.3.5 What has not been achieved – what barriers exist and what changes need to be made?
6.8.3.6 What new needs and goals are emerging?
6.8.4 The care plan will be updated by the case manager at the end of the review.