Care Plan Examples

The following GDCP examples were developed during three ‘change team’ workshops, by clinicians from Inner East Community Health Service, Manningham Community Health Service, Monashlink Community Health Service and Whitehorse Community Health Service.

The care plan examples are a guide, not a prescription. We cannot make judgments or assumptions about what goals have been included or not included. A GDCP should focus on capacity building, be strengths based, and include functional outcomes. These examples are not perfect, but are to demonstrate how to present a care plan and the language that can be used. It is important to remember to consider all the Healthy Ageing Principles as you develop care plans with your clients – even the principles that may be outside of your clinical scope of practice.

EMR HADP CARE PLAN

Name: *Nadia* UR: *XXXX* Date Care Plan Developed: *03/07/2013*

People Involved: *Nadia and Physio* Date For Review: *End August 2013*

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?

To improve my walking so I can catch the bus to my community activities.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME	COMPLETED
Nadia had left knee replacement in early May. Her recovery was complicated by Bronchitis, which she still has. This is limiting her ability to walk outdoors. Her family are supportive and take her shipping and to medical appointments. She has Home Care from the local council every 2 weeks.	*I want to be able to walk to the bus stop to be able to get to the Russian Club.*	*Increase the distance walked outdoors each day. The distance will depend on ability to exercise due to shortness of breath.*	*Nadia*	*Daily until end of August.*	
	I want to improve the strength in my left knee so that I feel more confident when walking outdoors.	*To do home exercise program as given by the physiotherapist. 10 repeats of each exercise x 2 daily.*	*Nadia*	*Twice daily until end of August.*	
		To use the walking stick loaned by the physio – only for walking outdoors.	*Nadia*	*Physio review at end of August.*	

Care Plan Provided To:		***Clinician Details: Physio***	
Client	Yes☒ No☐		
Family / Carer	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒
Other Services:	Yes☐ No☐ NA☒	Name/s:	Client Consent: Yes☐ / No☒

Client Acknowledgement:

I understand and agree to this care plan: *Nadia* (client) (and/or carer)

Verbal consent if not signed: Client: Yes☐ No☐ Carer: Yes☐ No☐ NA☐

Care Plan Audit

Audit criteria	Rationale	Scale
1. The client has a documented care plan.	A care plan should be documented utilising the approved template / format that provides an overview of the way in which the service will support the client achieve their goals.	1 - Yes 0 - No
2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented.	It is not always appropriate to formally set goals and develop a care plan for a client, however the rationale for not completing the care plan should be documented as per organisational procedures.	1 - Yes 0 - No 0 - N/A
3. The date that the care plan was completed is recorded.	Readers should be able to quickly identify when the care plan was completed.	1 - Yes 0 - No
4. The people involved in the development of the care plan are recorded.	Person centred care highlights the importance of actively engaging the client and other relevant people (including carers, friends, family and other service providers) in the development and review of the care plan. The names of the people involved in care planning should be clearly documented (including roles and organisations where relevant).	1 - Yes 0 - No
5. The writing in the care plan is legible.	In order to be useable, a care plan needs to be easily able to be read	1 - Yes 0 - No
6. The language used in the care plan is appropriate to the client.	The care plan should be written in language that is appropriate to the client, without the use of complex terminology or acronyms.	1 - Yes 0 - No
7. The care plan provides an overview of the current context / current situation.	The care plan should include a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This should provide adequate detail to enable to reader to understand how the subsequent goals fit into the clients overall life or context. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns.	2 - Always 1 - Sometimes 0 - Never
8. The goals set clearly demonstrate what the client hopes to achieve.	The goals should identify what the client hopes to achieve (in the short or long term). The goals may include hopes within and beyond the scope of services provided by your organisation.	2 - Always 1 - Sometimes 0 - Never
9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals.	The documented action/s should provide an overview of how staff will work with the client and other relevant people (including carers, family and other service providers) to support the achievement of each goal.	2 - Always 1 - Sometimes 0 - Never
10. There are appropriate timeframes recorded for when each action will be completed.	Specific timeframes should be articulated for each action, and reflect the client's needs and priorities. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process. For some actions (e.g. sending a referral), it is relevant to define a specific date for completion. For other actions (e.g. daughter to provide transport until volunteer driver in place) it may be more appropriate to record a timeframe (i.e. 4-6 weeks).	2 - Always 1 - Sometimes 0 - Never
		Subtotal (Q 1 – 10) 13 / 13

Care Plan Audit

Audit criteria	Rationale	Scale
11. The person / people responsible for implementing each action are documented.	In order to demonstrate clear accountability, a specific person should be assigned responsible for each action. In order to support a collaborative approach, it is important to document the actions to be completed by staff, the client, carers and other relevant team members.	2 - Always 1 - Sometimes 0 - Never
12. There is a clear link between the actions and goals that are documented.	Based on the care plan alone, readers should understand how each action relates to achieving the relevant goal/s.	2 - Always 1 - Sometimes 0 - Never
13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals.	A person centred approach requires staff to think beyond the scope of their service and support clients to address their goals in a holistic way. The care plan should reflect that, where appropriate, the client has been supported to access other relevant services to achieve their goals (e.g. via communication with and/or referrals made to other team members / organisations).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
14. There is evidence that the care plan is individualised and client centred.	In order to be person centred, the goals set should reflect the individual needs and wishes of the client and be clearly linked to the client's current situation / context. Goals and actions that are generic or reflect the services needs are not appropriate to be documented on a care plan.	2 - Always 1 - Sometimes 0 - Never
15. A date or timeframe has been documented for when the whole care plan needs to be reviewed.	In order to remain relevant, care plans need to be regularly reviewed. The time frame set for review will depend on the type of goals set and the timeframes for the achievement of these goals.	1 - Yes 0 - No
16. Client acknowledgement.	The client should sign the care plan, acknowledging that they have been actively involved in the development of the care plan and that they are happy with the information and actions included. NB: Documentation of verbal acknowledgement is also appropriate.	1 - Yes 0 - No
17. There is evidence that a copy of the care plan was provided or offered to the client.	In order for a care plan to be acted on by the client, they need written documentation as a record of the process.	1 - Yes 0 - No
18. There is evidence that, where appropriate, the care plan has been shared with relevant people.	Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
		Subtotal (Q 11 – 18) 13 / 13
		CARE PLAN DEVELOPMENT TOTAL 26 / 26

EMR HADP CARE PLAN

Name: *Mary* UR: *XXXX* Date Care Plan Developed: *15/06/2013*

People Involved: *Mary, Jean (mother), Sam (father), Physio, OT* Date For Review: *Early Sept 2013*

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?

I want to be able to get out of the house.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME	COMPLETED
Mary is a 41 year old lady with a long term physical disability affecting her leg strength and walking. She uses crutches to walk. *She finds it difficult to leave her home as she has 6 steps at the front door and is unsafe to walk down these.* *She lives with her parents who provide all meals and her mother assists with personal care. Her parents are concerned that she spends all day in her room, and eats her meals in her room, and would like her to spend more time interacting with the family.* *Mary has other health issues which affect her motivation and ability to change her behaviour.*	*Mary wants to be able to get out of her home to access the community.*	*Decide on preferred options for ramp as quoted by Archicentre.* *Mary to advise OT of decision.* *OT to complete funding application.* *Once ramp is installed, Physio to work with Mary regarding activities she would like to be involved in outside the home.*	*Mary, Jean and Sam* *Mary* *OT* *Physio and Mary*	*1 month* *1 month* *By end of July.* *Once ramp is installed – approx. 12-18 months.*	
	Mary wants to improve her confidence when walking in the home.	*Mary will complete home exercise program provided by the physio aiming to increase leg strength and balance.*	*Mary – Jean and Sam will encourage this.*	*Daily for 3 – 6 months.*	
	Jean and Sam would like Mary to spend more time interacting with her family.	*This is currently not a high priority for Mary. Did not wish to take action.*	*Physio to revisit this during review appointments.*	*Not determined.*	

Care Plan Provided To:		***Clinician Details:*** ***Physio***	
Client	Yes☒ No☐		
Family / Carer	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒
Other Services:	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒

Client Acknowledgement:

I understand and agree to this care plan: *Mary* (client) (and/or carer)

Verbal consent if not signed: Client: Yes☐ No☐ Carer: Yes☐ No☐ NA☐

Care Plan Audit

Audit criteria	Rationale	Scale
1. The client has a documented care plan.	A care plan should be documented utilising the approved template / format that provides an overview of the way in which the service will support the client achieve their goals.	1 - Yes 0 - No
2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented.	It is not always appropriate to formally set goals and develop a care plan for a client, however the rationale for not completing the care plan should be documented as per organisational procedures.	1 - Yes 0 - No 0 - N/A
3. The date that the care plan was completed is recorded.	Readers should be able to quickly identify when the care plan was completed.	1 - Yes 0 - No
4. The people involved in the development of the care plan are recorded.	Person centred care highlights the importance of actively engaging the client and other relevant people (including carers, friends, family and other service providers) in the development and review of the care plan. The names of the people involved in care planning should be clearly documented (including roles and organisations where relevant).	1 - Yes 0 - No
5. The writing in the care plan is legible.	In order to be useable, a care plan needs to be easily able to be read	1 - Yes 0 - No
6. The language used in the care plan is appropriate to the client.	The care plan should be written in language that is appropriate to the client, without the use of complex terminology or acronyms.	1 - Yes 0 - No
7. The care plan provides an overview of the current context / current situation.	The care plan should include a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This should provide adequate detail to enable to reader to understand how the subsequent goals fit into the clients overall life or context. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns.	2 - Always 1 - Sometimes 0 - Never
8. The goals set clearly demonstrate what the client hopes to achieve.	The goals should identify what the client hopes to achieve (in the short or long term). The goals may include hopes within and beyond the scope of services provided by your organisation.	2 - Always 1 - Sometimes 0 - Never
9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals.	The documented action/s should provide an overview of how staff will work with the client and other relevant people (including carers, family and other service providers) to support the achievement of each goal.	2 - Always 1 - Sometimes 0 - Never
10. There are appropriate timeframes recorded for when each action will be completed.	Specific timeframes should be articulated for each action, and reflect the client's needs and priorities. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process. For some actions (e.g. sending a referral), it is relevant to define a specific date for completion. For other actions (e.g. daughter to provide transport until volunteer driver in place) it may be more appropriate to record a timeframe (i.e. 4-6 weeks).	2 - Always 1 - Sometimes 0 - Never
		Subtotal (Q 1 – 10) 13 / 13

Care Plan Audit

Audit criteria	Rationale	Scale
11. The person / people responsible for implementing each action are documented.	In order to demonstrate clear accountability, a specific person should be assigned responsible for each action. In order to support a collaborative approach, it is important to document the actions to be completed by staff, the client, carers and other relevant team members.	2 - Always 1 - Sometimes 0 - Never
12. There is a clear link between the actions and goals that are documented.	Based on the care plan alone, readers should understand how each action relates to achieving the relevant goal/s.	2 - Always 1 - Sometimes 0 - Never
13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals.	A person centred approach requires staff to think beyond the scope of their service and support clients to address their goals in a holistic way. The care plan should reflect that, where appropriate, the client has been supported to access other relevant services to achieve their goals (e.g. via communication with and/or referrals made to other team members / organisations).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
14. There is evidence that the care plan is individualised and client centred.	In order to be person centred, the goals set should reflect the individual needs and wishes of the client and be clearly linked to the client's current situation / context. Goals and actions that are generic or reflect the services needs are not appropriate to be documented on a care plan.	2 - Always 1 - Sometimes 0 - Never
15. A date or timeframe has been documented for when the whole care plan needs to be reviewed.	In order to remain relevant, care plans need to be regularly reviewed. The time frame set for review will depend on the type of goals set and the timeframes for the achievement of these goals.	1 - Yes 0 - No
16. Client acknowledgement.	The client should sign the care plan, acknowledging that they have been actively involved in the development of the care plan and that they are happy with the information and actions included. NB: Documentation of verbal acknowledgement is also appropriate.	1 - Yes 0 - No
17. There is evidence that a copy of the care plan was provided or offered to the client.	In order for a care plan to be acted on by the client, they need written documentation as a record of the process.	1 - Yes 0 - No
18. There is evidence that, where appropriate, the care plan has been shared with relevant people.	Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
		Subtotal (Q 11 – 18) 13 / 13
		CARE PLAN DEVELOPMENT TOTAL 26 / 26

EMR HADP CARE PLAN

Name: *Nam* UR: *XXXX* Date Care Plan Developed: *03/07/2013*

People Involved: *Nam and Physio* Date For Review: *End Jan 2014*

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?					
Nam wants to start doing things in the community again.					
CURRENT SITUATION	**GOAL**	**ACTIONS**	**PERSON RESPONSIBLE**	**TIMEFRAME**	**COMPLETED**
Nam is 78 years old and has Type 2 diabetes which is not well managed at the moment. Her husband of 55 years died last year. Name lives in her own home with a lot of support from children and grandchildren. Nam has a lot of pain in her knees, is overweight and often feels tired. She uses a walking stick, but is feeling insecure so has been staying home except for 2 times weekly Tai Chi with her friends at the Vietnamese Women's Association.	*I want to get my knees better so I can go shopping in Victoria Street.*	*Visit GP to discuss regular use of Panadol Osteo.* *Complete leg strengthening exercises given by physio.* *Start walking 2 x 10 minutes daily.* *Use anti-inflammatory cream prescribed by GP over knees.* *Buy good walking shoes – use podiatry handout to help.*	*Nam and daughter* *Nam* *Nam* *Nam* *Nam and daughter*	*1 week* *Daily until end of August.* *From 04/07/13* *3 times daily for one month.* *End July.*	
	I want to have confidence to go out on bus trips with my friends again.	*Attend No Falls exercise program at XXXX Community Health Service to increase leg strength and improve balance.*	*Nam*	*3 – 6 months.*	

Care Plan Provided To:		***Clinician Details: Physio***	
Client	Yes☒ No☐		
Family / Carer	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒
Other Services:	Yes☐ No☐ NA☒	Name/s:	Client Consent: Yes☐ / No☒

Client Acknowledgement:

I understand and agree to this care plan: *Nam* (client) (and/or carer)

Verbal consent if not signed: Client: Yes☐ No☐ Carer: Yes☐ No☐ NA☐

Care Plan Audit

Audit criteria	Rationale	Scale
1. The client has a documented care plan.	A care plan should be documented utilising the approved template / format that provides an overview of the way in which the service will support the client achieve their goals.	1 - Yes 0 - No
2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented.	It is not always appropriate to formally set goals and develop a care plan for a client, however the rationale for not completing the care plan should be documented as per organisational procedures.	1 - Yes 0 - No 0 - N/A
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5. The writing in the care plan is legible.	In order to be useable, a care plan needs to be easily able to be read	1 - Yes 0 - No
6. The language used in the care plan is appropriate to the client.	The care plan should be written in language that is appropriate to the client, without the use of complex terminology or acronyms.	1 - Yes 0 - No
7. The care plan provides an overview of the current context / current situation.	The care plan should include a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This should provide adequate detail to enable to reader to understand how the subsequent goals fit into the clients overall life or context. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns.	2 - Always 1 - Sometimes 0 - Never
8. The goals set clearly demonstrate what the client hopes to achieve.	The goals should identify what the client hopes to achieve (in the short or long term). The goals may include hopes within and beyond the scope of services provided by your organisation.	2 - Always 1 - Sometimes 0 - Never
9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals.	The documented action/s should provide an overview of how staff will work with the client and other relevant people (including carers, family and other service providers) to support the achievement of each goal.	2 - Always 1 - Sometimes 0 - Never
10. There are appropriate timeframes recorded for when each action will be completed.	Specific timeframes should be articulated for each action, and reflect the client's needs and priorities. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process. For some actions (e.g. sending a referral), it is relevant to define a specific date for completion. For other actions (e.g. daughter to provide transport until volunteer driver in place) it may be more appropriate to record a timeframe (i.e. 4-6 weeks).	2 - Always 1 - Sometimes 0 - Never
		Subtotal (Q 1 – 10) 13 / 13

Care Plan Audit

Audit criteria	Rationale	Scale
11. The person / people responsible for implementing each action are documented.	In order to demonstrate clear accountability, a specific person should be assigned responsible for each action. In order to support a collaborative approach, it is important to document the actions to be completed by staff, the client, carers and other relevant team members.	2 - Always 1 - Sometimes 0 - Never
12. There is a clear link between the actions and goals that are documented.	Based on the care plan alone, readers should understand how each action relates to achieving the relevant goal/s.	2 - Always 1 - Sometimes 0 - Never
13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals.	A person centred approach requires staff to think beyond the scope of their service and support clients to address their goals in a holistic way. The care plan should reflect that, where appropriate, the client has been supported to access other relevant services to achieve their goals (e.g. via communication with and/or referrals made to other team members / organisations).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
14. There is evidence that the care plan is individualised and client centred.	In order to be person centred, the goals set should reflect the individual needs and wishes of the client and be clearly linked to the client's current situation / context. Goals and actions that are generic or reflect the services needs are not appropriate to be documented on a care plan.	2 - Always 1 - Sometimes 0 - Never
15. A date or timeframe has been documented for when the whole care plan needs to be reviewed.	In order to remain relevant, care plans need to be regularly reviewed. The time frame set for review will depend on the type of goals set and the timeframes for the achievement of these goals.	1 - Yes 0 - No
16. Client acknowledgement.	The client should sign the care plan, acknowledging that they have been actively involved in the development of the care plan and that they are happy with the information and actions included. NB: Documentation of verbal acknowledgement is also appropriate.	1 - Yes 0 - No
17. There is evidence that a copy of the care plan was provided or offered to the client.	In order for a care plan to be acted on by the client, they need written documentation as a record of the process.	1 - Yes 0 - No
18. There is evidence that, where appropriate, the care plan has been shared with relevant people.	Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
		Subtotal (Q 11 – 18) 13 / 13
		CARE PLAN DEVELOPMENT TOTAL 26 / 26

EMR HADP CARE PLAN

Name: *Sue* UR: *XXXX* Date Care Plan Developed: *03/07/13*

People Involved: *Sue and Physio* Date For Review: *6 months*

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?					
Sue wants to be pain free and would like regular hands-on treatment of her back pain.					
CURRENT SITUATION	**GOAL**	**ACTIONS**	**PERSON RESPONSIBLE**	**TIMEFRAME**	**COMPLETED**
Sue is a 60 year old teacher who has chronic pain and major depression. She is managed by a GP only for anti-depressants. Sue does no exercise because she is afraid of pain. She attends physio for hands-on treatment of her back. Sue is noticing that she is putting on weight and the pain is getting worse. She has attended a psychologist but didn't get anything out of this.	*I want to be pain free.*	*Hands-on physio treatment is contingent on attending regular exercise classes with the treating physio.* *Commence attending land based and hydro exercise classes to increase strength and flexibility.* *Refer to GP for referral to St Vincents chronic pain clinic.* *Refer to dietitian for weight loss advice.* *Walk to the coffee shop to read the paper every day.*	*Sue* *Sue* *Physio* *Physio* *Sue*	*Over the next 6 months with gradual decrease in hands-on treatment.* *From 10/07/13 – ongoing over next year at least.* *Next week.* *Daily ongoing.*	*Appointment 12/07/13*

Care Plan Provided To:		***Clinician Details: Physio***	
Client	Yes☒ No☐		
Family / Carer	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒
Other Services:	Yes☐ No☒ NA☐	Name/s:	Client Consent: Yes☐ / No☒

Client Acknowledgement:

I understand and agree to this care plan: Sue (client) (and/or carer)

Verbal consent if not signed: Client: Yes☐ No☐ Carer: Yes☐ No☐ NA☐

Physio Care Plan Example 7

Care Plan Audit

Audit criteria	Rationale	Scale
1. The client has a documented care plan.	A care plan should be documented utilising the approved template / format that provides an overview of the way in which the service will support the client achieve their goals.	1 - Yes 0 - No
2. If the client does not have a care plan, the rationale for not completing the care plan is clearly documented.	It is not always appropriate to formally set goals and develop a care plan for a client, however the rationale for not completing the care plan should be documented as per organisational procedures.	1 - Yes 0 - No 0 - N/A
3. The date that the care plan was completed is recorded.	Readers should be able to quickly identify when the care plan was completed.	1 - Yes 0 - No
4. The people involved in the development of the care plan are recorded.	Person centred care highlights the importance of actively engaging the client and other relevant people (including carers, friends, family and other service providers) in the development and review of the care plan. The names of the people involved in care planning should be clearly documented (including roles and organisations where relevant).	1 - Yes 0 - No
5. The writing in the care plan is legible.	In order to be useable, a care plan needs to be easily able to be read	1 - Yes 0 - No
6. The language used in the care plan is appropriate to the client.	The care plan should be written in language that is appropriate to the client, without the use of complex terminology or acronyms.	1 - Yes 0 - No
7. The care plan provides an overview of the current context / current situation.	The care plan should include a brief summary of the current situation, including the key issues that the client hopes to address through their care plan. This should provide adequate detail to enable to reader to understand how the subsequent goals fit into the clients overall life or context. The current context may include key points around the person's priorities, capacities, values, supports, issues and concerns.	2 - Always 1 - Sometimes 0 - Never
8. The goals set clearly demonstrate what the client hopes to achieve.	The goals should identify what the client hopes to achieve (in the short or long term). The goals may include hopes within and beyond the scope of services provided by your organisation.	2 - Always 1 - Sometimes 0 - Never
9. Actions are recorded for each goal and clearly outline the key steps that need to be completed in order to achieve the goals.	The documented action/s should provide an overview of how staff will work with the client and other relevant people (including carers, family and other service providers) to support the achievement of each goal.	2 - Always 1 - Sometimes 0 - Never
10. There are appropriate timeframes recorded for when each action will be completed.	Specific timeframes should be articulated for each action, and reflect the client's needs and priorities. This enables a care plan to be easily reviewed and helps to set out expectations for each party involved in the care planning process. For some actions (e.g. sending a referral), it is relevant to define a specific date for completion. For other actions (e.g. daughter to provide transport until volunteer driver in place) it may be more appropriate to record a timeframe (i.e. 4-6 weeks).	2 - Always 1 - Sometimes 0 - Never
		Subtotal (Q 1 – 10) 13 / 13

Care Plan Audit

Audit criteria	Rationale	Scale
11. The person / people responsible for implementing each action are documented.	In order to demonstrate clear accountability, a specific person should be assigned responsible for each action. In order to support a collaborative approach, it is important to document the actions to be completed by staff, the client, carers and other relevant team members.	2 - Always 1 - Sometimes 0 - Never
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13. There is evidence that, where appropriate, other staff / service providers have been engaged to support the client achieve their goals.	A person centred approach requires staff to think beyond the scope of their service and support clients to address their goals in a holistic way. The care plan should reflect that, where appropriate, the client has been supported to access other relevant services to achieve their goals (e.g. via communication with and/or referrals made to other team members / organisations).	2 - Always 1 - Sometimes 0 - Never 2 - N/A
14. There is evidence that the care plan is individualised and client centred.	In order to be person centred, the goals set should reflect the individual needs and wishes of the client and be clearly linked to the client's current situation / context. Goals and actions that are generic or reflect the services needs are not appropriate to be documented on a care plan.	2 - Always 1 - Sometimes 0 - Never
15. A date or timeframe has been documented for when the whole care plan needs to be reviewed.	In order to remain relevant, care plans need to be regularly reviewed. The time frame set for review will depend on the type of goals set and the timeframes for the achievement of these goals.	1 - Yes 0 - No
16. Client acknowledgement.	The client should sign the care plan, acknowledging that they have been actively involved in the development of the care plan and that they are happy with the information and actions included. NB: Documentation of verbal acknowledgement is also appropriate.	1 - Yes 0 - No
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18. There is evidence that, where appropriate, the care plan has been shared with relevant people.	Communication of key information and the care plan is fundamental to interagency involvement and to delivering coordinated care. Given client consent, care plans should be shared with people involved in the delivery of care (including carers, family, staff and other services providers). Having obtained consent to share within your agency means this does not need to be specifically stated on the care plan.	2 - Always 1 - Sometimes 0 - Never 2 - N/A
		Subtotal (Q 11 – 18) 13 / 13
		CARE PLAN DEVELOPMENT TOTAL 26 / 26