Top tips for documenting GDCP

We know that staff are committed to working in person centred ways and constantly tailor their approach to match each client's priorities, strengths and abilities. Often though, staff report that translating this approach into writing and documenting meaningful GDCPs is challenging. This resource provides tips about how to document a GDCP that can become a valuable tool for you and your clients. Further information is available in the Goal Directed Care Planning Toolkit.

First and foremost, it is essential to remember that a GDCP is a tool for the client!

It should provide a brief overview of the client's current situation, their goals and how you will work together to achieve those goals. It should be developed with the client and provide them with the opportunity to be involved in making decisions about how you will work together. With that in mind, remember to:

- Only include information that is meaningful and relevant to the client
- Ensure that the GDCP is legible and that the language is appropriate for the client (avoid jargon and acronyms)
- Encourage the client to use their GDCP as a reminder to complete the actions they are responsible for, track progress and to communicate with others about how you are working together.

The right tool for the job

To make it as easy as possible to document quality GDCPs, you need to ensure that your tool is simple, easy to use and provides prompts to document the information required to meet the relevant quality standards. It may be useful to start by reviewing your GDCP template using the '*Audit tool for care planning templates*' (please refer to Chapter 3 of the Goal Directed Care Planning Toolkit).

What to document

In order to meet the quality standards, a client's GDCP needs to include the following information:

- When the care plan was developed (date)
- Who was involved in the development of the care plan
- Summary of current situation / context
- Agreed goal/s
- Actions, with assigned responsibility & timeframes
- Who the care plan has been (or will be) shared with
- When the care plan will be reviewed
- Acknowledgement that the client has understood and agreed to the care plan.

This resource was jointly funded by the Commonwealth and Victorian Governments

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Breaking it down

Staff feedback and audit results indicate that many staff have difficulty documenting the current situation in a person centred, strengths based way and differentiating between goals and actions. Included below are some tips to assist you with each of these sections:

Documenting the current situation

The GDCP should include a very brief snapshot of the client's situation that provides the context for why you are working together. It should be short and simple - you don't need to include every detail. To support a strengths based approach, you should capture key information about the person's life, interests abilities and challenges that provides a summary of why you are working together, not just a list of all the issues or problems.

Documenting Goals

The goals should describe the specific outcomes that the client wants to achieve. The goals may be specific to the work that you are doing together, or they may include broader life goals. This should be determined by what is important to the person.

Goals should:

- Describe the specific outcome the person wants to achieve
- Be meaningful within the context of the person's life
- Be action oriented (I want to be, do, feel, maintain …)
- Be written in first or third person (Jenny wants, or I want. Avoid patient/client wants).

Documenting Actions

The actions should clearly outline the steps that will be taken to support the client achieve their goals. The person responsible and the timeframe for completing each action should also be documented – this is more likely to be included when the care planning template includes specific spaces to document this information.

Checking whether you have documented the right information

A useful way to review whether you have included the correct information is to imagine another team member was going to conduct a review with the client. Ask yourself whether the care plan includes the relevant information for that person to initiate a meaningful conversation with the client about how you have been working together, the impact of your intervention and whether their needs are being met.

You can also assess your documentation more formally, using the '*Audit tool for Completed Care Plans*' (refer to Chapter 5 of the Goal Directed Care Planning Toolkit).

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Example 1: Fran

Provided below is an excerpt of a client's care plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a GDCP (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME
87 year old woman, lives alone Osteoarthritis – pain and swelling in both hands Increasing difficulty with ADLs Son's concerned about safety at home ***This doesn't provide us with a summary of who Fran is or provide any context about why you are documenting a care plan for her.*** ***Instead, this is an issues list that outlines only the problems that Fran is experiencing.***	Joint protection strategies ***Joint protection strategies are an action. This doesn't describe what Fran wants to achieve by learning the joint protection strategies.***	OT Assessment ***This does not clearly outline the next steps – how is Fran going to access the OT?*** ***Because the action is written incorrectly, it becomes difficult to document the person responsible and the timeframe.***	OT	6 weeks
Another way to write this would be:				
Fran is keen to remain living in her own home and is willing to explore services and strategies to help her stay independent. Fran's fingers are very stiff and sore from her arthritis and she is finding cooking, housework and gardening difficult. Fran's 2 sons John and Paul are very supportive. They both live an hour away and take turns to visit every weekend. They are worried about Fran but want to support her to continue living at home and are willing to help out with any chores on the weekends.	Fran wants to continue cooking her own meals at home without aggravating her joint pain	Refer to OT at local Community Health Service to discuss strategies and equipment to assist Fran while cooking	Jess (Assessment officer)	Friday 2/3/14

Example 2: George

Provided below is an excerpt of a client's care plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a GDCP (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME
73 year old man living home alone. Socially isolated, no family support. Visual retinopathy secondary to his diabetes GP recently advised him to stop driving ***While this does provide us with some information about George, it is quite negative and doesn't provide us with the information we need to be able to check back in with George and understand whether the care plan is meeting his needs***	Attend Men's Group ***Attending the group is an action. The goal should describe what George wants to achieve (i.e. why attending the group will be valuable for George).***	Do hands on activities that George enjoys ***Because the action has been documented previously (as the goal), it is difficult to describe the next steps, without being repetitive.*** ***The person responsible should be a specific person (or you can describe their specific role). Documenting the name of the organisation / service is inadequate.*** ***The timeframe should describe when the specific next step will be completed. In this case, 'ongoing' is inappropriate.***	PAG	Ongoing
Another way to write this would be:				
George was a plumber for many years and loves working with his hands. He recently stopped driving due to poor vision. He feels frustrated that he can't get out alone and is bored being home alone all day.	I want to get out of the house regularly and feel that I'm being productive	Register George in the Men's Shed program every Tuesday and Friday.	Barb (Men's Shed coordinator)	Commence 1/4/14

Example 3: Charlie

Provided below is an excerpt of a client's care plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a GDCP (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME
OA, OP, R TKR 2011 Persistent pain and stiffness right LL – exacerbated during exercise ***This is a list of clinical issues. It does not provide an overview of who the client is or the context of why a care plan is being developed It also includes a number of acronyms and is not documented in language that is appropriate for the client.***	Increase strength and exercise tolerance ***This is very generic and does not describe the outcome that Charlie is hoping to achieve. By increasing the strength in Charlie's knee, what will he be able to do / feel etc.?***	PT 1/7	PT	Weekly
		Home Exercise Program	Charlie	Daily
		Hydrotherapy ***The actions do not clearly describe the next steps required for each of these actions. In order for Charlie to join the hydrotherapy program, what needs to happen next? Need to avoid acronyms***	PT	15/5/14
Another way to write this would be:				
Charlie had a left total knee replacement in 2011 with good results. He has arthritis in his right knee and has been advised by his surgeon that in the future he may also need a right knee replacement. The pain in his right knee has steadily increased and it is very stiff in the mornings. Charlie no longer feels confident walking long distances and wants to delay surgery as long as possible. Charlie has recently retired and wants to join his friends for a weekly game of golf.	I want to increase the strength in my right knee so that I can build up to playing 18 holes of golf each week.	Attend weekly physio appointments for 6 weeks for education and treatment to address pain in right knee	Charlie & Physio	Weekly – commencing 15/5/14
		Complete Daily Home Exercise Program as provided by Physio	Charlie	Ongoing
		Refer to Hydrotherapy Coordinator for an assessment and introduction to weekly hydrotherapy group	Physio	15/5/14

Example 4: John

Provided below is an excerpt of a client's care plan along with notes (in red) about the improvements required. Below this, an example of how this information could be re-written is included (in purple). Please note that this excerpt does not include all of the information required in a GDCP (e.g. dates, who was involved etc.) and is intended only as an example of common documentation challenges.

CURRENT SITUATION	GOAL	ACTIONS	PERSON RESPONSIBLE	TIMEFRAME
23 year old man with Cystic Fibrosis who lives at home with mum, dad and 3 younger sisters. Able to independently feed and toilet himself, requires min assistance with showering and dressing due to fatigue and breathlessness. No equipment in bathroom. Ambulates independently with 4WF indoors and uses wheelchair for long distances. Attends day program 3/7. Receives overnight respite with host family monthly. Mum is full time carer – recently hurt her back. Advised by PT to rest for 12/52. Back pain aggravated by manual handling, unable to assist PADLs.	Showering assistance	Council PCA	Case Manager	ASAP
	Bathroom review	OT review	OT	1/52
Given that the GDCP is a tool for the client, much of this information is irrelevant. John and his mum will be aware of their living situation and John's abilities. The key information that provides the context for this care plan is that mum has recently hurt her back and is having difficulty providing support while she recovers.	***These goals are actions – they describe what the other services will provide. Instead, the goals should describe what John and his mum hope to achieve by initiating these additional***	***The Actions should clearly outline the next steps (i.e In order to access personal care from the council, WHO is going to do WHAT?) Acronyms (e.g. PCA or 1/52) are not appropriate within a GDCP. The timeframe should be agreed and documented as a specific time in which the action will be completed.***		
Another way to write this would be:				
John and his family are well supported and feel they have been coping well with existing supports. Mum recently hurt her back and is undergoing treatment. Her back pain is aggravated when assisting John in the shower. John and Mum are keen to review bathroom set up and access some additional short term support over the next 12 weeks while she is recovering.	Ensure John can safely shower while Mum is recovering from her back injury	Refer to Council for assessment re. short term assistance with showering	Case Manager	15/5/14
		Liaise with John's OT re. need for a reassessment to review bathroom setup and showering strategies	Mum	18/5/14