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Care Planning Tips

The home care industry continues to focus on client-centric care, where an integral part of that includes developing customized care plans. The care planning process does not have to be tedious or complicated, and this worksheet will walk you through 5 steps to help you build and implement better care plans for your clients. Each step includes our recommendations, but we encourage you to add additional notes that are specific to your agency.

WORKSHEET →

Make your care plan goals and objectives SMART.

By making your goals and objectives SMART for the caregiver, it allows for an objective measure when care or service is completed.

How do you start implementing it?

- Review current state – your organization may have already partially implemented SMART objectives as it was a common quality improvement measure in 2018
- Define what needs to change about your current care plans and care planning process to implement a smarter practice
- Identify if electronic system supports process change – how easy to update/evaluate/add new goals to a care plan

By making your goals and objectives SMART for the client, it allows for informed consent and agreement on goals of care.

How do you maintain this process moving forward?

- Ongoing review and support
- Education
- Job Aids

Assign care plan actions (especially interventions) to a discipline or individual.

Assigning care plan actions will help the caregiver to keep themselves and the agency accountable, as well as avoid issues from falling through the cracks and not getting addressed.

How do you start implementing it?

- Review current state
- Assigning responsibility supported in the documentation system – is it a required field, is it configured, is it done
- Identify who is responsible for every task in the care plan – if accountability can't be determined, should it be in the care plan?

Assigning care plan actions will help the client, as it provides the client with a clear understanding of the full circle of care, as well as ensure client's care needs are met.

How do you maintain this process moving forward?

- Review and feedback to staff
- Potentially work with your software vendor to identify processes that support analytics to identify gaps

Balance the care plan between clinical best practices and your client specific needs.

Balancing care plans between clinical best practices and your client specific needs will help the caregiver expedite the client care plan building process Avoid staff missing a standard of care item.

How do you start implementing it?

- Review the current state of your organization and what you're currently using
- What are the gaps to implement – e.g. standards or libraries, documentation system support.
- What are the resources that are used for "information and referral" – package that information as needed.

Balancing care plans between clinical best practices and your client specific needs will help the client engage in their own health planning and allow them to understand standards or usual practices.

How do you maintain this process moving forward?

- Review and feedback
- Address gaps and challenges along the way

Incorporate the care plan into the care workflow.

Incorporating the care plan into the care workflow will support caregivers to work towards specific goals, ensure documentation supports the care plan and make incremental evaluation.

How do you start implementing it?

- Review your current state
- Leverage documentation already in place for the client
- Communicate with the circle of care and client using the care plan and its language.

Incorporating the care plan into the care workflow will support the client to have visibility into their progress, see their incremental changes and achieved goals.

How do you maintain this process moving forward?

- Review and provide feedback
- Reinforce the change

Evaluate both the goals being met and those that are not

Evaluating goals will help the caregiver meet regulatory requirements, verifies that the plan of care was completed (or not), and allows for adjustments to be made to interventions that are not working.

How do you start implementing it?

- Review current state
- Is it currently happening – any blockers?
- Is it “easy” to document and can it be reported back to client for visibility?
- Plan formal evaluation but also informal feedback

Evaluating goals will help the client to be involved in their own health journey and own their health and wellness, celebrate goals achieved and provide feedback when goals are not met.

How do you maintain this process moving forward?

- Review and feedback
- Reinforce the change