Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

Shared Care Plans – Frequently Asked Questions

Q. What is an Acute Plan?
A. An Acute Plan is for patients with complex health needs at risk of attending acute services over the next 12 months and is a tool to assist clinicians who don't know the patient's history or social context to safely and effectively manage the urgent care of patients with complex or specific health needs.

Q: What is a Personalised Care Plan?
A: The PCP documents person-centred issues, goals and actions. This allows a care team to work with the person to coordinate care around their needs and priorities. It contains information from the person about what is most important to them at present.

Q. What is an Advance Care Plan?
A. The ACP is the process of thinking about, discussing, and legally documenting a person's wishes about the type and level of medical care and treatment they want to receive at the end of life (or) when they can't speak for themselves.

Q: Who can write a Shared Care Plan?
A: A Shared Care Plan can be written or amended by any clinician involved in the patients care.

Q. Who are Shared Care Plans written for?
A. Patients with complex health needs.

Q. Why would I write a Shared Care Plan?
A. As well as supporting people with complex health needs to self-manage, it allows the work of services involved in supporting the person to be made visible to other services.

Q: Where would I find a Shared Care Plan?
A: The Shared Care Plans are visible on Health Connect South (HCS).
(Community based services use HealthOne to access HCS)

Q: Who are the plans shared with?
A: Clinicians who are involved with a person's care and the individual themselves.

Q: Can a patient have more than 1 plan?
A: Yes. A person can have all three Shared Care Plans. Often people with a Shared Care Plan will have complex health needs and the potential to experience a serious event when they cannot speak for themselves. Having an AP will help communicate important clinical information with the health teams involved in their care, the PCP will ensure their goals are

recognised and an ACP will help ensure their wishes and preferences are used to guide care if they are at their end of life.

Q: What is a Medical Care Guidance plan?

This is similar to an ACP and is designed for those who permanently lack capacity and have not previously completed an ACP. It is completed by a doctor in consultation with the person's EPoA/family and is "guidance" only (intended as clinical notes).

Q: How will I access support for care plan creation?

A: Guidance on writing care plans is on both Hospital and Community HealthPathways
For IT and access assistance, contact your IT service desk.
For more information on shared care plans email:
Rebecca.muir@ccn.health.nz or Jules.wilke@ccn.health.nz