# Shared Care Plans

## Where to find the plans

The plans sit within Health Connect South as below:

## Acute Plan

CARE PLAN

Clinical Docs | Patient Tasks | Care Plans | Eclair (NW) | HealthOne | Problem List | Appts | Eclair | Cortex | Obs | Southern | Clinical Resources | Clinical Notices | Record Access

Clinical Do
Showing All
Group By Category Sort
Dynamic Patient Summar
Anthropometrics
Add New Document
Clinical Documents (3)

Patient Demographics

Suspect Duplicate...

Gender M
Date of Birth 23/12/1940
Ethnicity NZ European
Phone
Mobile
Address 133 Bucklands Beach Road , Bucklands Beach , AUCKLAND 2012

View Contact Details...

Patient GP Information

No GP Information available

Shared Care Plans

| Status | Plan Name | Created | Last Modified By | Last Modified |
|---|---|---|---|---|
| FINAL | Acute Plan | 18-Jun-2018 | Rebecca Muir | 06-Jul-2018 |
| DRAFT | Advance Care Plan | 05-Jul-2018 | Gavin Young (CREST) | 05-Jul-2018 |
| FINAL | Personalised Care Plan | 19-Jul-2018 | Rebecca Muir | 12-Sep-2018 |

Adverse Reactions

ADVERSE REACTION Filter Applied

UNKNOWN No active adverse reactions recorded.

Alert Summary

EXTERNAL SOURCES ( 0 )
NHI Medical Warnings (Last R 12:45)
No problems received
SIPICS Alerts (Last Refreshed
No problems received
Homer Alerts
No problems received

# Personalised Care Plan

CARE PLAN

Clinical Docs | Patient Tasks | Care Plans | Eclair (NW) | HealthOne | Problem List | Appts | Eclair | Cortex | Obs | Southern | Clinical Resources | Clinical Notices | Record Access

- Home
- Circle Of Care
- Community Health Pathways
- Hospital Health Pathways
- Shared Progress Note

Personalised Care Plan

| What matters most to the patient at the moment |
|---|
| I would love to be mobile enough to take my grandchildren out to the park |

Shared Care Plans

| Status | Plan Name | Created | Last Modified By |
|---|---|---|---|
| FINAL | Acute Plan | 29-Sep-2017 | Gavin YOUNG (CREST) |
| FINAL | Advance Care Plan | 05-Aug-2020 | Gavin YOUNG (CREST) |
| FINAL | Personalised Care Plan | 13-Nov-2018 | Kathryn SLOCOMBE |

Note:

The information in this form will be viewable by health care providers across primary, secondary and community services.
This Care Plan may be audited for quality purposes.

Search / Print Goals

Goals — Show All — Update Progress

**Daily Activity-Work/Education/Leisure /Exercise**
Issue: Pain when walking Goal: Take pain killers and increase d...
Added by Gavin YOUNG (CREST) on 13-Aug-2019
START 13-AUG-19
*There are no progress measurements for this goal.*

**Legal/Financial**
Issue: Worried about future of husband Max Goal: Set up plan...
Added by Gavin YOUNG (CREST) on 13-Nov-2018
START 13-NOV-18 | 07-MAY-19 | 07-MAY-19 | 07-MAY-19

Search / Print Actions

Actions — Show All

- Referral to OPMH for Max to assess for respite care
  Emotional Wellbeing/Mental Health
- Complete EPOA for Max. Given information about this and will need to see Law work
  13-Mar-2019 Legal/Financial
- practice slow breathing strategy and complete on-line mindfulness course
  31-Oct-2019 Emotional Wellbeing/Mental Health

## How to get Started

**Shared Care Planning - A guide to identification of vulnerable patients in general practice.**

**For clinician use in the creation of the Acute Plan (AP) and the Personalised Care Plan (PCP)**

| **Practice system/technology** | **Provider referrals** |
| --- | --- |
| • Query builds around specific condition/diagnosis. Pegasus - GP viewother practices - Dr Info<br>  - Conditions include COPD, other respiratory, CVD, diabetes, mental health, complex social issues, and age. Previous CarePlus, high user card, palliative<br>• Flu vac lists, COVID risk lists, frail elderly, and isolated lists<br>• Frequent attenders to the practice, criteria set by practice forexample: 6 visits in 6 months | • St John – identify patients and phone or email the practice<br>• Māori health providers including Te Puawaitanga ki Ōtautahi Trustidentify patients and phone or email practice<br>• Community pharmacy referrals for patients on multiple medicinestherefore multi complex conditions<br>• Community providers e.g., CREST, district nursing<br>• Mental Health NGO 's e.g., community support workers |
| **CDHB Connections / Data Informed** | **In practice identification by the Practice team** |
| • Lists of patients with Chronic Obstructive Pulmonary Disease<br>• Lists of patients at risk of inappropriate polypharmacy - 10 or moremedications matched to ED admissions<br>• Palliative leads – make direct contact when a new patient is referredinto their service<br>• ED daily presentations, summaries, and discharge reports | • Doctor identifies patients in consultation based on formedrelationship.<br>• Nurses identify patients via triage, working on the floor and in nurseclinic.<br>• Spouse of partner with dementia or in care.<br>• Ethnicity<br>• Patients with cognitive or intellectual impairment or disability (e.g.,hearing or speech) which impairs their ability to communicate effectively<br>• Patients that display difficult or challenging behaviour, have recurrentbehaviour tending towards aggression<br>• Patients who present with self-harm<br>• Patients who present as drug seekers<br>• Patients who present with recurrent falls<br>• Patients with rare conditions who need appropriate management in acrisis<br>• Patients requesting a plan as part of complaints resolution |

# Case Studies

## Acute Plan

**Sharon**

- Age: 28
- Ethnicity: Māori
- Presents to acute services with severe abdominal pain 3-4 times a year
- She has severe endometriosis causing adhesions, infertility, recurrent small bowel obstruction
- She has a pain plan negotiated with pain clinic (copied in plan)

**Plan could include:**

- Please don't treat her as a drug seeker or talk much about pregnancy as both approaches will distress her
- Please manage pain as per attached pain plan and check for bowel obstruction

User and patient stories on the acute plan can be found here:

https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning/ArticleID/5649

https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning/ArticleID/5609

https://ccn.health.nz/Blog/ArticleID/1957

## Personalised Care Plan

**Joan**

- Age: 77,
- Ethnicity: Pakeha
- You have completed an assessment on Joan aged 77
- She has diabetes and hasn't been coping at home with her husband.
- Carer stress, increase in diabetes symptoms
- Joan is well educated re what she needs to do to manage her diabetes but struggling with diabetes, lacks motivation.
- Sad about not being able to attend her granddaughter's wedding in 12 months due to being not well enough to fly
- Joan has been seen by Older Persons Health who can see and add to her PCP

**Plan could include:**

- What matters most to Joan "attending my granddaughters wedding in Australia"
- Goals: to lose 10 KG, identify relevant actions that will be required for her to achieve her goal.
- Document the goals and actions in the PCP, alongside this you can record the progress in the shared progress notes section.

## Claiming for Plan

General practice can claim for preparation or full review of a shared care plan as follows:

**Fee calculation:**
Preparing or fully reviewing a plan usually takes around 10 to 30 minutes depending on complexity.

**Claim process**
Claim via Pegasus ePortal and include the following information in these fields:

- Other fee – enter your fee
- Other fee description
- Time taken to complete

More information about claiming can be found on health pathways

**https://canterbury.communityhealthpathways.org/65695.htm**

**https://canterbury.communityhealthpathways.org/456252.htm**

## Need more information?

**Community Health Pathways**

- Step by step guidance

**Health Info**

- Care Plan information for patients

Patient brochures are available electronically
https://ccn.health.nz/Portals/18/DNNGalleryPro/uploads/2020/4/7/Sharedcareplans.pdf

Printed copies can be ordered from community and public health
https://www.cph.co.nz/resources/shared-care-plans/

**Canterbury Clinical Network Website**

Additional resources available;

https://ccn.health.nz/Our-Work/Other-Alliance-Groups-Enablers/Shared-Care-Planning

https://ccn.health.nz/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=4719&language=en-GB&PortalId=18&TabId=2444

https://ccn.health.nz/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=5396&language=en-GB&PortalId=18&TabId=2444

**Contact the Shared Care Plan Team** info@ccn.health.nz

## Link to the Webinar Evaulation Form

https://forms.office.com/r/d2ZXTYunGs or Webinar: Shared Care Planning