World Health Organization

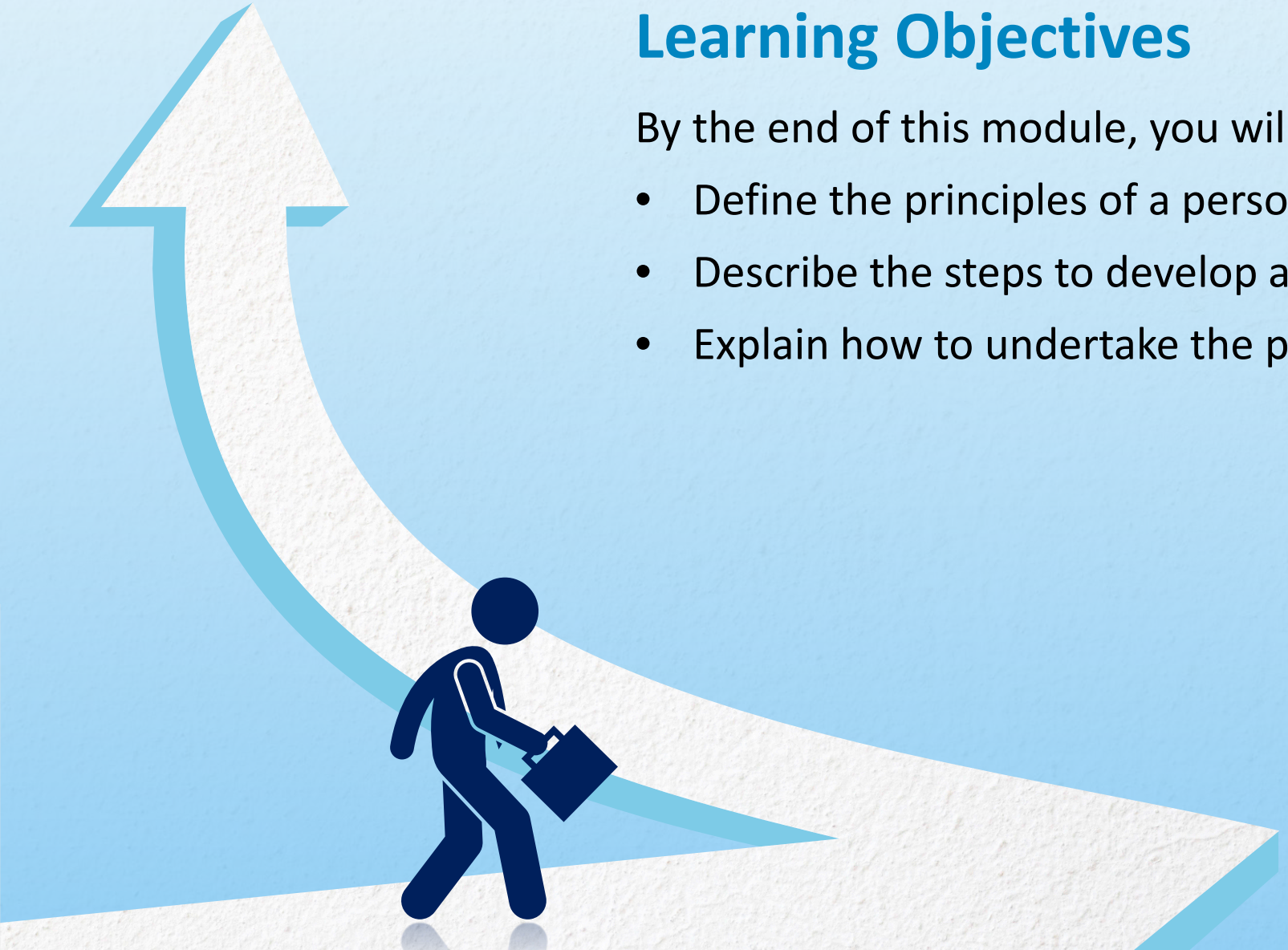
Version 0.1
Draft version for field testing

ICOPE

INTEGRATED CARE FOR OLDER PEOPLE

PERSONALISED CARE PLAN

WHO / Quinn Mattingly



Learning Objectives

By the end of this module, you will:

- Define the principles of a personalised care plan.
- Describe the steps to develop a personalised care plan.
- Explain how to undertake the person-centred goal setting.

Principles of a Personalised Care Plan

Person-centred, holistic approach to tailor care through a collaborative action of health and care workers and the active involvement of the older person, his/her family and caregivers

A multidisciplinary teams may improve the assessment and management of the older person's needs, allowing the design of a care plan more responsive to his/her priorities

Interventions are designed using a shared decision-making process involving the older person, the family and caregivers.

Follow-up and monitoring are critical to ensure the achievement of goals.

Recommendations for Action

1 Review findings and discuss opportunities to improve functional ability, health and well-being

- *Multidisciplinary approach*
- *Generate a list of proposed interventions to be potentially included in the care plan*
- *Support from ICOPE material, including the ICOPE app*
- *Discuss with the older person his/her objectives, goals, and expectations*
- *Include everyone involved in the older person's care*

Recommendations for Action

1 Review findings and discuss opportunities to improve functional ability, health and well-being

2 Person-centred goal setting

- *Involve the older person in the decision-making process*
- *Understand and respect needs, values, preferences, priorities*
- *Adequately consider issues outside the clinical domain*
- *Set realistic short-, medium- and long-term goals*

Recommendations for Action

1. **Review findings and discuss opportunities to improve functional ability, health and well-being**
2. **Person-centred goal setting**
3. **Agree on interventions**

- *Agreement by the older person and eventual caregiver*
- *In line with his/her goals, needs, preferences and priorities*
- *Accommodate physical and social environment*

Recommendations for Action

1 Review findings and discuss opportunities to improve functional ability, health and well-being

2 Person-centred goal setting

3 Agree on interventions

4 Finalise and share the care plan

- *Document the care plan*
- *Share the plan with the person, family members, caregivers and other involved in the care (ask consent as appropriate)*
- *ICOPE material, including ICOPE app, can support*

Recommendations for Action

1. **Review findings and discuss opportunities to improve functional ability, health and well-being**
2. **Person-centred goal setting**
3. **Agree on interventions**
4. **Finalise and share the care plan**
5. **Monitoring and follow-up**

- *Monitor progress, detect emerging difficulties, apply eventual adaptations*
- *Ensure the care plan is successfully implemented*
- *Plan re-assessment and re-evaluation over time to document changes*
- *Regularly update the plan according to documented changes and evolving priorities*

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How to Undertake Person-Centred Goal Setting

Identify Goals

Identify goals with the older person, their family members and caregivers

QUESTION 1
Please explain the things that matter to you most in all parts of your life.

QUESTION 2
What are some specific goals that you have in your life?

QUESTION 3
What are some specific goals that you have for your health?

QUESTION 4
Based on the list of both life and health goals we just discussed, can you pick three that you would like to focus on in the next three months? What about in the next six to 12 months?

Set Goals

Goals can be adapted to older people's needs and their own definition of problems.

QUESTION 5
What specifically about goal one, two or three would you like to work on over the next three months? What about over the next six to 12 months?

QUESTION 6
What are you currently doing about [goal area]?

QUESTION 7
What would be an ideal yet possible target for you in achieving this goal?

Prioritise Goals

Agreement on prioritised goals of care between older people and providers will demonstrate improved outcomes.

QUESTION 8
Of these goals, which one are you most willing to work on over the next three months – either by yourself or with support from [Dr XX and their team]? What about over the next six to 12 months?


WHO / Blink Media - Juliana Tan

Summary

- The design of a personalised care plan for older persons implies the collaborative action of a multidisciplinary team
- Interventions are aligned with the older person's priorities and include monitoring and follow-up plans
- Steps to develop a personalised care plan:
  - Review findings and discuss opportunities to improve functional ability, health and well-being
  - Person-centred goal setting
  - Shared decision-making process involving the older person and eventual caregiver
  - Sharing of the care plan
  - Monitoring and follow-up activities with regular re-evaluations of the care plan over time.