ICOPE

INTEGRATED CARE FOR OLDER PEOPLE

PERSONALISED CARE PLAN

Facilitator Guide: Module 17

World Health Organization

Contents

Introduction to the Guide

Welcome to the Facilitator Guide for the WHO Integrated Care for Older People (ICOPE). This guide serves as a roadmap for the facilitators, helping them navigate through the session while ensuring that key topics are covered and participants are engaged. It may also include tips, potential challenges and suggested ways to handle different situations that may arise during the session.

Iconography

The following icons are used in the Facilitator Guide to indicate the type of content being presented.

Icon	Action	Description
	Session Title	Indicates the name of the session being conducted.
	Session Objectives	Lists the learning objectives to be achieved.
	Timing	Indicates the duration of the session or activity.
	Show	Indicates the slide to be presented.
	Say	What to say or explain while facilitating. It will contain the recommended script/ answers to be discussed.
	Ask	Ask the participants a question and encourage them to respond.
	Do	What to do to facilitate an activity or provide guidance to learners.
	Play	Indicates a video clip to be presented.

Session Structure

This facilitator guide is organised according to the way you will present the material on each slide:

- **Show** – The slides
- **Say** – This is a scripted narrative outline for you.
- **Ask** – Questions to prompt dialogue with and among the participants
    - The dialogue associated with the questions should take between 5 to 10 minutes. However, you will need to use your best judgement about the time to dedicate to the question-and-answer sessions. Some sessions may last longer.
- **Do** – Prompts you to do an action

Keep in mind that this Facilitator Guide is only a roadmap. You are expected to apply your own voice and experience in making this tool work for you. The 'Say' sections are simply indications; you can use them as a script when you feel the need to, but you can and should adapt it to suit your natural training style.

Add your own personal touch and personality to every training, while being careful to stick to the session objectives.

A key component of successful face-to-face training is establishing trust and rapport with your learners. Use your own good judgment to assess the attitude and cultural sensitivities of the people in your workshop. Adapt your training techniques and approach accordingly.

You are going to be great at conducting this training.

Module 17: Personalised Care Plan

	Session Title:	**Personalised Care Plan**
	Timing:	10 min
	Session Objectives:	• 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.

Personalised Care Plan

Time: 10 min

Do:

- *Formal welcome*
- *Introduction of facilitator*

Show: Slide 1

Say:

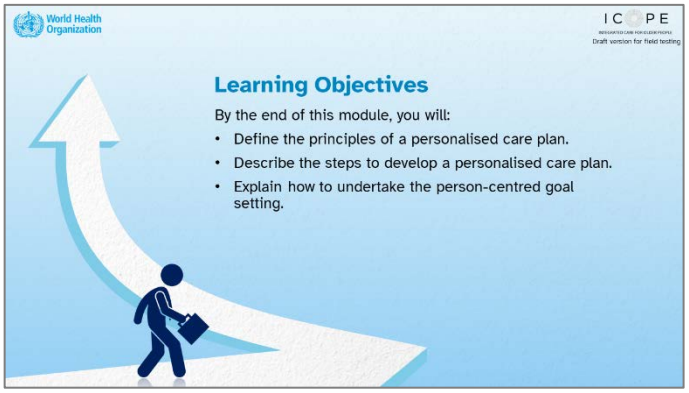
Welcome to the module on personalised care plans for older people. In this session, we will cover the following.

- Core principles of personalised care plan
- Steps to develop a personalised care plan
- Person-centred goal setting and how to do it

We'll delve into these topics to gain a comprehensive understanding of implementing care for healthy ageing. Let's get started.

Learning Objectives

Show: Slide 2



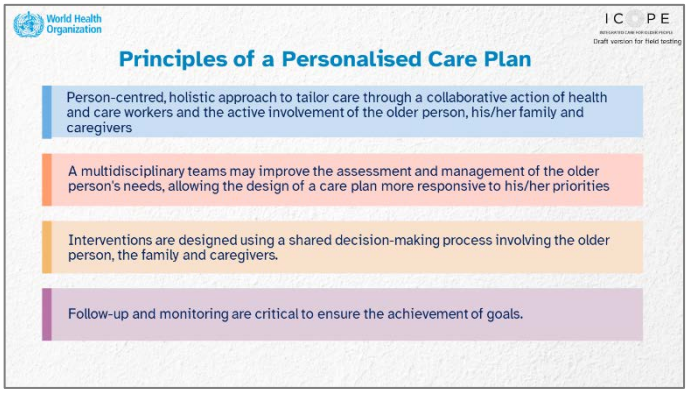
Say:

By the end of this module, you'll have a solid grasp of essential components for effective care of older people. We'll cover:

1. **Principles of a Personalised Care Plan:** You'll understand how these plans are tailored to meet older people's needs, incorporating personal goals, preferences, and values.
2. **Steps to Develop a Personalised Care Plan:** It starts with a comprehensive assessment of the older person's needs and goals, setting realistic and achievable goals, identifying necessary resources and support, and regularly reviewing and adjusting the care plan.
3. **Undertake Person-Centered Goal Setting:** This empowers patients to actively participate in their care by setting goals.

Principles of a Personalised Care Plan

Show: Slide 3



Say:

A personalised care plan is based on a few basic principles.

Principle 1: Person-Centred, Holistic Approach

A person-centred, holistic approach tailors care through collaborative action among health and care workers, with active involvement from the older person, their family, and caregivers. This ensures that the care provided is truly aligned with the older person's needs and preferences.

Principle 2: Multidisciplinary Teams

Multidisciplinary teams can enhance the assessment and management of an older person's needs, allowing for a care plan that is more responsive to their priorities. By combining the expertise of various professionals, we can create a comprehensive and effective care strategy.

Principle 3: Shared Decision-Making

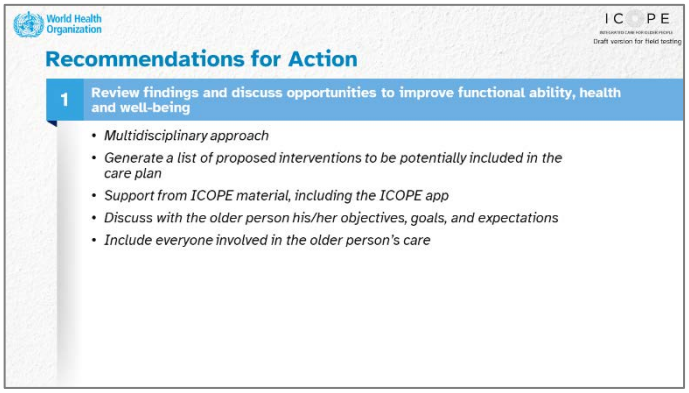
Interventions are designed using a shared decision-making process that involves the older person, their family, and caregivers. This collaborative approach ensures that all perspectives are considered, making the care plan more personalised and sustainable, and increasing adherence to it.

Principle 4: Follow-Up and Monitoring

Regular follow-up and monitoring are critical to ensure the achievement of goals. By continuously assessing progress and making necessary adjustments, we can maintain the relevance and effectiveness of the care plan over time. This also allows us to intervene in a timely and preventive manner to modify the plan according to the evolution of the person’s condition.

Recommendations for Action – Recommendation 1

Show: Slide 4



Say:

Now, let's review the recommendations for improving personalised care plans for older people. Our first recommendation is to **review the findings and discuss opportunities to improve the older person's functional ability, health, and well-being**.

This recommendation encompasses several aspects to consider:

Multidisciplinary Approach

Involving professionals from various fields helps develop a more comprehensive and effective care plan that addresses all of the older person's needs.

Generate Proposed Interventions

Generate a list of possible interventions to propose and potentially include in the care plan. These should be tailored to the older person's specific needs and preferences based on the initial assessment.

Utilise ICOPE Material

Utilise resources from the ICOPE material, including the ICOPE app. These tools offer valuable guidance and can enhance the quality of the care plan.

Discuss Objectives with the Older Person

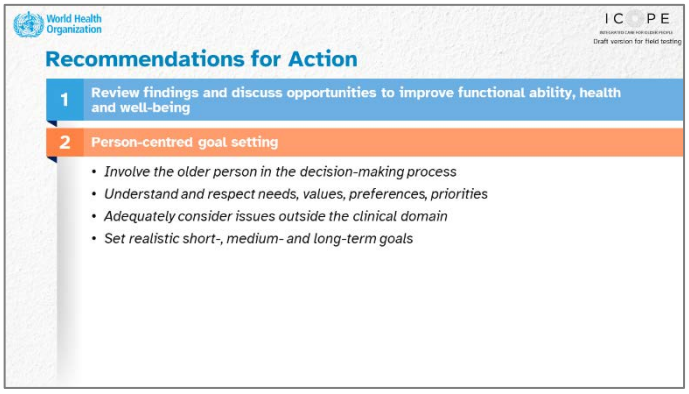
Engage in discussions with the older person about their objectives, goals, and expectations. This ensures their voice is central to the care planning process, making the plan truly personalised.

Include All Caregivers

Include everyone involved in the older person's care in these discussions. This means involving family members and caregivers to ensure a unified and supportive approach to the patient's care.

Recommendations for Action – Recommendation 2

Show: Slide 5



Say:

Let's move on to our second recommendation: **person-centred goal setting**. This involves several important factors to take into account to ensure the care plan is truly aligned with the older person's needs and aspirations:

Involve the Older Person in Decision-Making

The active participation of the older person in the decision-making process ensures that the care plan reflects his/her desires and priorities.

Understand and Respect Needs, Values, and Preferences

Take the time to understand and respect the older person's needs, values, preferences, and priorities. This deep understanding is crucial for creating a care plan that is meaningful and relevant to them.

Consider Issues Outside the Clinical Domain

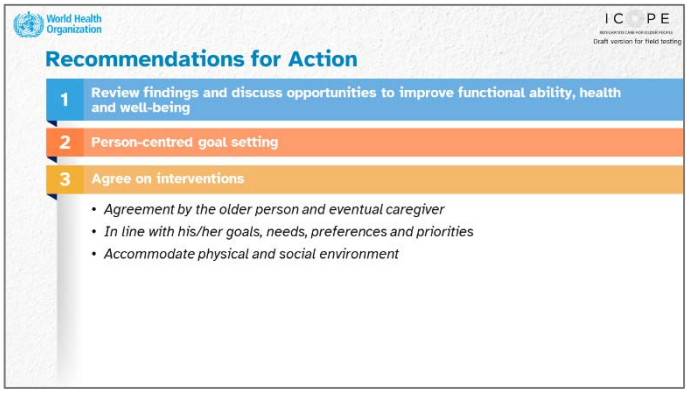
Adequately consider issues outside the clinical domain. This includes social, emotional, and environmental factors that can significantly impact the older person's well-being.

Set Realistic Goals

Set realistic short-, medium-, and long-term goals. These goals should be achievable and tailored to the older person's situation, providing clear milestones to work towards.

Recommendations for Action – Recommendation 3

Show: Slide 6



Say:

Now, let's discuss our third recommendation: **agreeing on interventions**. This process involves several critical aspects to ensure the interventions are appropriate and effective:

Agreement by the Older Person and Caregiver

First, ensure agreement on the interventions from both the older person and his/her caregiver. Their consent and cooperation are essential for successful implementation.

Align with Goals, Needs, Preferences, and Priorities

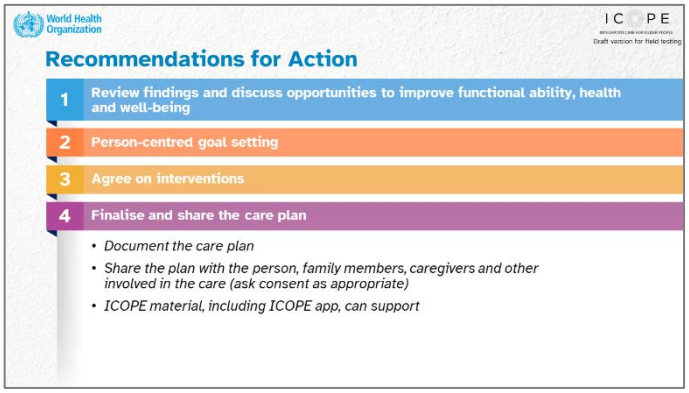
Ensure the interventions align with the older person's goals, needs, preferences, and priorities. This alignment ensures that the care provided is truly person-centred and relevant.

Accommodate Physical and Social Environment

Finally, when planning interventions, accommodate the older person's physical and social environment. This consideration helps make the interventions practical and sustainable in their daily lives.

Recommendations for Action – Recommendation 4

Show: Slide 7



Say:

Let's move on to our fourth recommendation: **finalising and sharing the care plan**. This recommendation involves a few key steps:

Document the Care Plan

First, ensure the care plan is thoroughly documented. Clear and detailed documentation is essential for consistency and reference.

Share the Care Plan

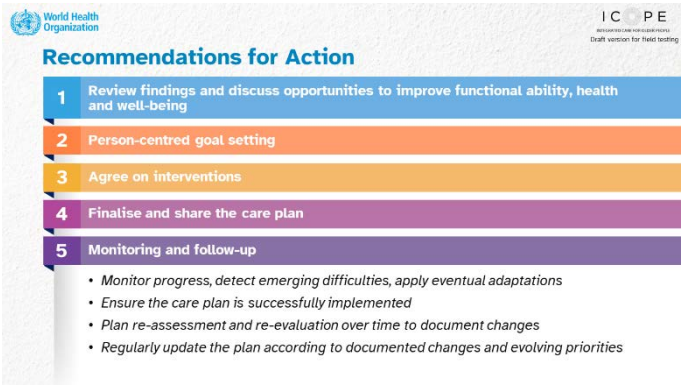
Share the finalised care plan with the older person, family members, caregivers, and others involved in the care. Make sure to ask for consent as appropriate to respect privacy and confidentiality.

Utilise ICOPE Material

Leverage resources from the ICOPE (Integrated Care for Older People) material, including the ICOPE app, to support the care plan. These tools can enhance the quality and implementation of the plan.

Recommendations for Action – Recommendation 5

Show: Slide 8



Say:

Finally, let's discuss our fifth recommendation: **monitoring and follow-up**. This is crucial to ensure the care plan remains effective and responsive. Here are the key steps:

Monitor Progress and Adapt

Monitor the older person's progress regularly, detect any emerging difficulties, and apply necessary adaptations. This ongoing vigilance ensures that the care plan remains relevant and effective.

Ensure Successful Implementation

Ensure that the care plan is successfully implemented. Regular check-ins help to confirm that all aspects of the plan are being followed and that the older person is receiving the intended care.

Plan Re-assessment and Re-evaluation

Plan for re-assessment and re-evaluation over time to document changes in the older person's condition. These periodic reviews are essential for understanding how the care plan works and what adjustments may be needed.

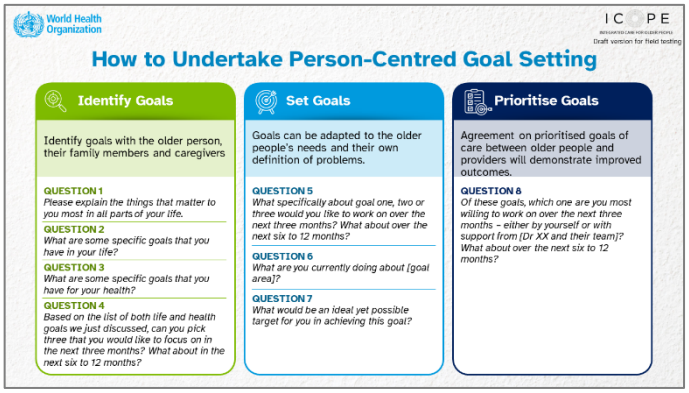
Update the Plan Regularly

Update the care plan regularly according to documented changes and evolving priorities. This dynamic approach ensures that the care plan continues to effectively meet the older person's needs.

By following these recommendations, we can maintain a responsive and effective care plan that adapts to the older person's changing needs and priorities.

How to Undertake Person-Centred Goal Setting?

Show: Slide 9



Say:

Let's discuss how to undertake person-centred goal setting, especially when working with older people. This process involves three key parts: identifying goals, setting goals, and prioritising goals.

Identify Goals

Firstly, we must identify the goals in collaboration with the older person, their family members, and caregivers. This step is crucial as it ensures that the goals reflect the older person's values and aspirations. Here are some questions you may want to consider to facilitate this discussion:

- *'Please explain the things that matter to you most in all parts of your life.'*
  - This question helps us understand what is truly important to the person in various aspects of their life.
- *'What are some specific goals that you have in your life?'*
  - Here, we encourage the person to articulate their broader life goals.
- *'What are some specific goals that you have for your health?'*
  - This question narrows the focus to health-related goals, which are often a priority for older people.
- *'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?'*
  - We ask this to help prioritise immediate and longer-term goals.

Set Goals

Once we've identified the goals, the next step is to set them. It's important to adapt these goals to the older person's needs and their definition of problems. Here are some guiding questions:

- *'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?'*
  - This question helps to break down the goals into actionable steps over specific time frames.

- *'What are you currently doing about [goal area]?'*
  - This helps us understand the current efforts and any ongoing actions related to the goals.
- *'What would be an ideal yet possible target for you in achieving this goal?'*
  - Here, we set realistic and achievable targets to work towards.

Prioritise Goals

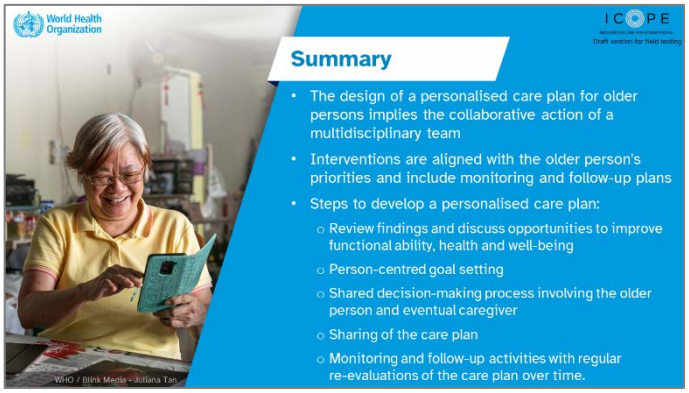
Finally, we need to prioritise the goals. Agreement on the prioritised care goals between older people and providers is essential for demonstrating improved outcomes. Some questions to ask may be:

- *'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?'*
  - This helps in identifying the most immediate and actionable goals and ensures that the older person is engaged and motivated to work towards them.

By following these steps, we can ensure that the goals are person-centred, realistic, and prioritised according to the older person's values and needs. This collaborative approach helps to achieve better outcomes and enhances the overall well-being of the older person.

Summary

Show: Slide 10



Do:

Go through the slides and recap the points discussed during the session.