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 person-centred goal setting.

Personalised Care Plan

Time: 10 min

Do:

- *Formal welcome*
- *Introduction of facilitator*

Show: Slide 1

Say:

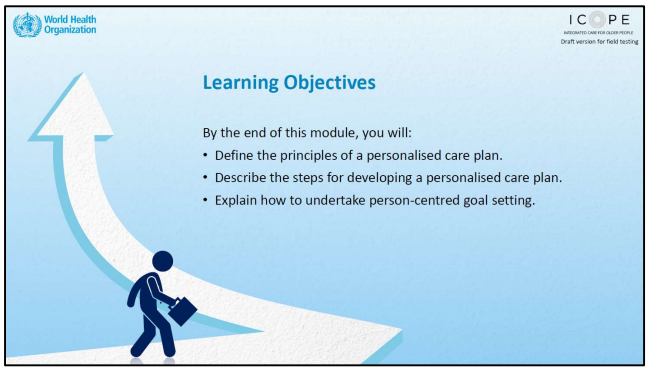
Welcome to the module on personalised care plans for older people. In this session, we will cover the following.

- 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



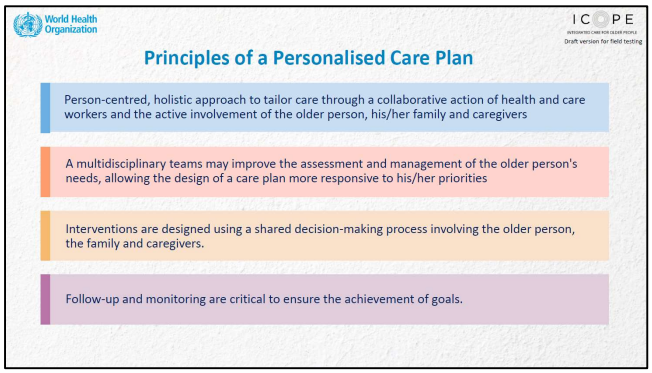
Say:

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.

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.

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.

3. Shared Decision-Making

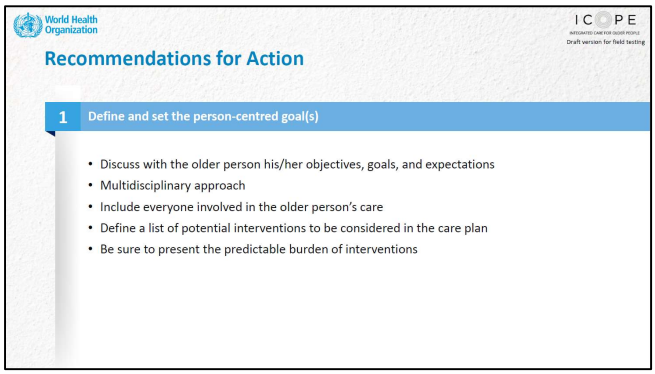
Interventions are designed using a shared decision-making process that involves the older person, their family, and caregivers. This collaborative approach ensures that all perspectives are considered, making the care plan more personalised and sustainable, and increasing adherence to it.

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 - 1

Show: Slide 4



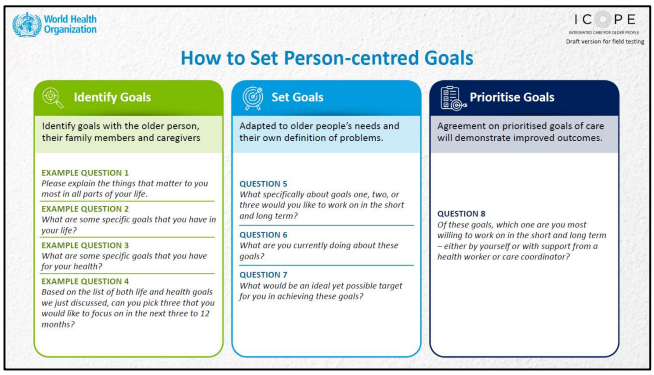
Say:

The starting point for developing a personalized care plan should be the older person's goals, identified through discussion with a health worker, ideally a doctor or nurse, led by a case manager or care coordinator. A doctor or nurse can fulfil the role of case manager/care coordinator. Health workers must involve the older person (and their carer(s), where appropriate) in decision-making about their own care, and respect their needs, values, preferences and priorities.

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. At the same time, be sure to present the predictable burden of interventions to avoid a loss of adherence to the plan because deviating from expectations.

How to Set Person-Centred Goals

Show: Slide 5



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

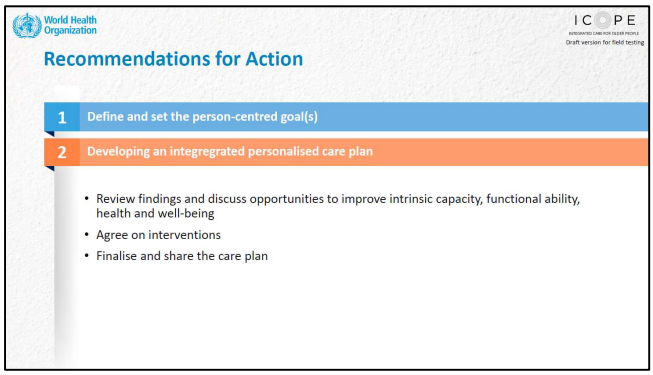
Finally, we need to prioritise the goals. Agreement on the prioritised care goals between older people and providers is essential for demonstrating improved outcomes. Some questions to ask may be:

- *'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.

Recommendations for Action – 2

Show: Slide 6



Say:

Three main steps should be considered in the development of a personalized care plan:

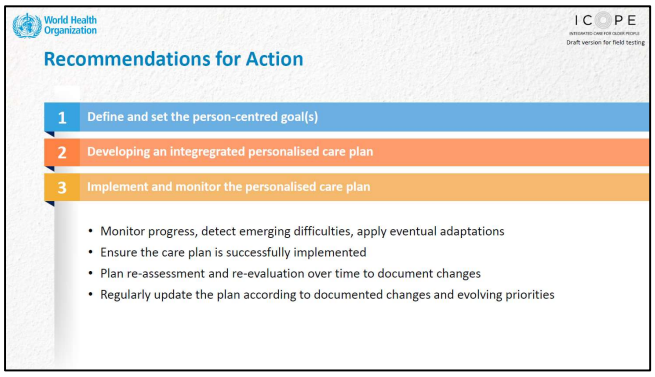
1. Review findings and discuss opportunities. During goal-setting discussions, it's important to review the results of assessments and suggested interventions for various intrinsic capacity losses. Interventions should be prioritized based on clinical urgency, likelihood of success, broader impacts, predictable burdens, and the older person's preferences. Health workers need comprehensive knowledge of available health and social services to determine potential interventions.

2. Agree on interventions. This agreement requires the older person's informed consent and alignment with their goals and preferences. It should include self-care components, accommodate their physical and social environments, and support caregivers where needed. Each intervention must be discussed individually with the older person. A partnership among the older person, their caregivers, and the multidisciplinary team is essential for sustaining their well-being.

3. Finalize and share the care plan. The case manager or care coordinator should document agreed interventions in the care plan and share it with the older person, their family, and the multidisciplinary team, with the person's consent. If referrals are needed, the older person should receive guidance on making appointments and how health workers can assist.

Recommendations for Action – 3

Show: Slide 7



Say:

Let's move on to our third recommendation: implement and monitor the personalised care plan.

A collaborative work by the multidisciplinary team led by a care coordinator is crucial for implementing personalized care plans. This approach allows the early detection of complications, addresses challenges from acute events, and identifies critical changes in social roles or intrinsic capacity.

This recommendation implies the need to:

- Monitor progress and detect any new or worsening issues.
- Adapt the plan as needed to respond to changes in health or circumstances.
- Ensure implementation through coordinated action by the care team.
- Reassess and re-evaluate regularly to keep the plan relevant and effective.
- Update the plan based on documented changes and evolving priorities.

Summary

Show: Slide 8

Do:

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