Comprehensive care webinar 5: Care planning

BEN: Good morning, everybody, and welcome to this, the fifth webinar in a joint collaboration between the Queensland Centre for Mental Health Learning and Insight on behalf of the mental health, alcohol, and other drugs branch. Today, we're going to be going through some information about care planning. We have some excellent presenters for you today. We'll be going through each of those in turn.

You will have the opportunity to ask questions through the chat, which will be monitored throughout the day. We have a question-and-answer section at the end. So any questions that you put in the chat will be recorded. And in the time that we have for the question-and-answer section, we'll do our very best to get through as many of those as we can.

In the chat, in a moment, you'll also find a resource sheet that contains links to a lot of information that is relevant to the presentations today. That will be coming later on in the chat. This session is also being recorded, and you'll have the ability to access that recording soon.

There's also an evaluation of this webinar that will be appearing at the end. So when you sign off Zoom today, if you wouldn't mind taking a few minutes to fill that out to help us improve this webinar series, then we would greatly appreciate that. So I hope you enjoy all the presenters today. I'm sure you will. And I will hand over to Darren Neely.

DARREN NEELY: Thank you. Thanks. Thanks, Ben. So my name is Darren Neely, and I've been the clinical lead on a project looking at care planning as part of the Comprehensive Care initiative.

And I'd like to start by acknowledging the traditional owners of the land on which this event takes place. And for where we are in Brisbane, that is the Jagera and Turrbal people. And I'd like to pay my respects to Elders past, present, and emerging.

I'd also like to acknowledge the lived experience of those with mental illness and those impacted by suicide or substance use and also acknowledge the contribution of family members, carers, friends, and staff and the contribution that they make to their recovery. Now, I just--

DARREN NEELY: Now, the purpose of today's webinar is really focusing on care planning. And care planning is a key clinical process that supports the delivery of comprehensive care. And it's been said, we've got a really interesting schedule for you, with a number of presenters who I'm really grateful to.

And you'll hear about care planning from different perspectives. You'll hear about projects that are underway in a few services that were started as part of the clinical network's Brief Breakthrough Collaborative. You'll hear about what the data tells us is happening with care planning across the state. And as Ben said, we also will highlight some resources for you, which are available in the handout that you'll have access to.

Now, the Care Planning Resource Guide is part of the broader Comprehensive Care Resource Guide to Formulation, Care Planning, and Case Review. And that was an outcome

from three projects involving three working groups that began in mid-2019 with the aim of standardising the approach to these processes. And you can find the resource guide with a number of other resources within the Comprehensive Care Resource Package on the Comprehensive Care internet site.

In addition to the aim of trying to standardise care planning, we wanted the resource guide to really identify what the purpose of and the principles are behind care planning, but also create something that would really be a useful, helpful, practical guide to the development and review of care plans, but also, within the broader Comprehensive Care Resource Guide, emphasise the links that there are between formulation, care planning, and case reviews. And those links-- you can see in the case history-- this is the Sandra case history that is also within the resource package.

Just to highlight some of the key principles and aspects to the process that we've articulated in the resource guide, firstly, care planning really needs to be a collaborative process, reflecting shared decision making. The language that is used is really important in making it an individualised process, a meaningful process, that really should reflect the consumer's narrative.

The care plan should bring together information from a range of sources. And in the resource guide, we've highlighted some examples of how you can integrate information from multiple sources. And the process of care planning is really a cyclical process of identifying, setting goals, implementing strategies, which then allows you to review the outcomes of the strategies and set new goals.

And I guess the purpose of the resource guide is really to identify for you the ingredients of care planning. How you apply the care planning process will vary at times. But ultimately, it's about that collaborative process and about the engagement.

And I just wanted to finish by highlighting the importance of leadership, both at a multidisciplinary team level but also an organisational level in valuing and prioritising care planning. And I just wanted to thank everyone that's been involved in the development of the resource guide.

So I'm going to stop there. And now I'm going to hand over to Katrina Baxter. And Katrina is an advanced peer worker with Metro South who's going to talk about care planning from a lived experience perspective as well as a peer worker perspective. So thank you, Katrina.

KATRINA BAXTER: Hey, guys, how are you? Can everyone see me and hear me?

BEN: We can. Thank you, Kat.

KATRINA BAXTER: OK, cool. So my name's Kat Baxter. I'm an advanced peer support worker within the mental health department here at Logan, inpatient. And I have a lived experience of AOD, mental health issues. My parents have significant mental health issues themselves.

I guess when we look at care planning in inpatient, for me, I'm going to be bringing this as more about my perspective and what my experience is from seeing the care plans and how they've been integrated into the person's recovery. So when I interpret the narrative that I receive from the care planning that I've seen, to me, it looks more like the language is more directed, to me, from my experience, as more of a clinical goal.

And the focus, to me, would probably be more around KPIs rather than it being more of a personalised plan. From my experience, I have read a care plan for one patient, and then I've seen another care plan for another patient that has been a direct cut and paste-- exactly the same words, exactly the same things that are said.

So in this, this led me to question how-- for example, my recovery plan-- how the recovery plan is supposed to reflect the care plan. So I spoke with my psychologist here that I work alongside with. And that's what she had mentioned to me, that the recovery plan needs to reflect the care plan. And I said, well, how is it supposed to reflect it when it, to me, doesn't seem personalised. It seems more of a clinical goal more than a personalised goal.

So here at Logan, we've done a couple of sessions in this pilot group called Back on Track group, which is focused around the recovery planning principles. And what this does is it allows us to sit in the group environment with the person's recovery plan with either myself, an allied health staff member, a nursing staff member.

And we either can write it on butcher's paper or post-it notes. And we go through each of the steps of my recovery plan. And we get to share it amongst the group and all talk to each other in the group, getting the peer lived experience amongst the patients themselves. And this is a really good way to fill this recovery plan out.

And I found that this has been more personalised, rather than the recovery plan being given to them, and then they fill it out, and it's just very, very limited in what has been written there. So having the person feel empowered that this is about them. It's in a group environment. They have lived experience recovery strategies amongst myself and others. Then we have the clinical there, guiding the conversations in directions to give them more of evidence-based reasons for the certain strategies we use and stuff.

But yeah, I guess that, from what I've seen, maybe-- I know that in community, when I was working in community, I had seen care plans that are-- obviously, they follow the guidelines. But they're very much more individualised. And it seems more consumer led rather than service led.

But that-- the narrative-- that's what I seem to be taking away from the care planning, from what I've seen so far in inpatient, is that not all, but some-- it's very much falling into cut and paste. And it's not very personalised. It seems more clinical. Yeah, so that's my experience from all of that. Thanks, guys.

BEN: Great, thank you for that, Kat. And Robyn, was there something that you wanted to say as well?

ROBYN TURK: Can everyone hear me?

BEN: Yes, we can hear you. Thanks, Robyn.

ROBYN TURK: Thank you. Welcome everybody. So my name is Robyn Turk. I'm a senior or advanced peer worker in the PA here in Brisbane. So reflecting from my own lived experience, care planning that I have had on my many admissions has been really, really important. It's actually helped and guided me with the nursing staff as an inpatient to share what I need.

And it's all about to the discharge. It's working towards what the collaborative team can bring to help me recover. It focuses on my discharge. And then the care plan can then reflect the

recovery plan in an inpatient environment and also, then, when you're in the community, and you're back to living at home.

With my experience, when I have been in an inpatient, it's very personal. The nurses and the staff have asked me what helps me in my time of grief and struggles and what will help me move forward in my recovery. So if I've shared that I need my mobile phone-- it helps me use my apps and things like that, too, for my anxiety and my depression and stuff like that-- so that's actually added on to my care plan.

Allowing, my husband would visit me. And the time frame was a little bit different. But he was my very main source of support. So there was a little bit of allowance for him to be there a little bit after when the wards were closed. And it's all that sort of stuff that really helped me have a shorter stay and also be focused for my recovery when I'm discharged.

So in my role here at the PA, I actually ask and look at some of the consumers' care plans that they have done with their nursing on admission. And if there's things there from my lived experience that aren't actually highlighted, I actually ask them, would this be a benefit to you?

And sometimes, they prefer not to add to it. And sometimes, they do. And then that's a collaborative thing for me, to have a chat with their allocated nurse and their treating team to share that they would like this added to their care plan. It actually does help them. Because I really believe it is very important.

And it starts from inpatient. And then we can add some of the care planning techniques that we've had here, also, on to their recovery plan. And then it's worked on with that team when they're back in the community with their family, with their friends. And it's really vital.

And here at the PA, it works very well. Some people are a little unwell, and they can't do that at that particular time. But it's something that we can keep going back to in a collaborative way, that we all do understand each other and understand that consumer needs for their recovery. I think that's about all I have. Thank you.

BEN: Beautiful. Thank you very much for that, Robyn. And now we are going to be handing over to Rick Bastida.

RICK BASTIDA: Thanks, guys. People can hear me?

BEN: Yes, we can hear you. Thanks, Rick.

RICK BASTIDA: Thanks. And slides. OK, I got control. All right, why care planning? What does the data tell us?

So as well as things like the national standards and generally good practise around having a care plan and a way documented of what's going to be the priorities and things that we're working towards when working with our consumers, some of the data elements in some of the surveys that we've got in the mental health sector have really showed that it's important to consumers to have a care plan and to be involved in care planning as a process.

So the Your Experience of Service, the YES survey-- the results from that. One of the questions particularly showed up. And that's question 21. So that talks about, in the last three months, what was your experience? And it asks around, were there developed-- I've just got to move you off to the side here-- the development of a care plan with you that considered all your needs?

And one of the key points of that question was that when there was analysis done to the national data set, the national data from the YES survey, it was found that that question had the biggest influence on overall satisfaction. And the Queensland data was analysed by the Queensland Government Statistician's Office and confirmed that with very similar findings. So care planning became a really important item that comes out of the YES survey.

So the clinical improvement team has been talking about outcome measures for quite a few years now. And we've always said that the outcome measures-- the HoNOS and the other outcome measures in the suite-- are an important element to helping direct care planning and help focus on the domains and those areas of the person's life that would benefit from the interventions that are able to be offered. The outcome measures can help focus on treatment planning and as part of the review process to constantly check over time.

As Darren said at the beginning, care planning is a cyclical process. So we can use the outcome measures and net goal setting and then the reviewing aspects. And that leaves in the middle the intervention, which is mostly your guys' place.

There's a few things that CIMHA does to help make care planning easier. And for those that haven't seen the videos, this link here is in the resource handout that was-- the link was posted before in the chat. So you can have a look at this video. It does talk through the various elements of the Comprehensive Care project. So it talks about not only care planning but the longitudinal summary, case review, and using some of the different forms in CIMHA, some of the different clinical note templates.

Ok, people will probably be aware that there's a measure of how we're doing around care plans as a proxy for the process of care planning. And we know that since we started measuring two or three years ago, we've had a great increase in the uptake and use of care plans in CIMHA. So we've gone from having just over 20% to, we reached a peak late last year of nearly 70% of our episodes having a care plan.

But it's not quite the same for all. So each of these represents 1 of the 21 mental health organisations in Queensland. And you can see there, there's quite a variation. So while it looks good and most are on the upward trend, there's still quite a lot of variation. So we've still got work to do. We're not quite there yet. That's me.

BEN: Excellent. Thank you for that, Rick. So now we'll hand over to Linda Hipper.

LINDA HIPPER: Hi, all. Hopefully, you can see me. So the AOD perspective on care planning, I think one of the important parts that I want to emphasise is that, oops, I need to go back. Care planning is not new to alcohol and drug services. It's been occurring for quite some time. And it's been called many different things. Locally, here, within Metro South, we've called it individual treatment planning. But ultimately, it's not new.

What is new has been the introduction of CIMHA 5.0 and the new template. So that has been quite new and quite challenging. But ultimately, the principles of care planning that have already been outlined in terms of it being collaborative, individualised, integrated, and that it aligns with the client's goals, as well as the clinical goals that are there, as well as it being ongoing, is what is very integrated into AOD teams. And so the history of care planning within AODS has that philosophy that the client's story remains the centre point of the process. And as I've said, it's ultimately about good clinical care.

There has been some confusion arisen around, what's the difference within CIMHA for some of the AOD clinicians between what is a recovery plan versus a care plan? Because I think

within, particularly here in Metro South, what we were doing with our individual treatment plans was that it was all in one, and it was the client's document. Rather than having a recovery plan and a care plan, it was all in one.

So I've just identified some of the current challenges that have been brought to my attention over time with the introduction of care planning within CIMHA. And a lot of the clinicians are feeding back to me that the new CIMHA process is seen as more of an operational process rather than a useful clinical tool.

I think it was Kat who mentioned that it can sometimes feel like it's about KPIs rather than about good, quality treatment planning. And that can also be a symptom of the quite large caseloads that are carried within the AOD teams, which can be quite different to some of the mental health teams.

So feedback is also saying that the current CIMHA template is very mental health focused, and that can add to the difficulties. I think it's sometimes that whole sense of, when you first open a document screen, and the first thing you see is, what is the mental health status that comes up on that care plan, and that is not relevant for a lot of the AOD clients, then it's a little bit off-putting from the very start.

Not saying that we don't do integrated care and that we don't have clients that have both co-occurring mental health and AOD issues. And that's one of the opportunities, I think, as well, is knowing. And how do we integrate different AOD and mental health care plans so that we are looking at that whole person?

The other challenge that's being sent my way is the additional clinical documentation time required in CIMHA 5.0, which clinicians are feeling is taking away from other clinical work. But this is ongoing. And November hasn't been that far away since when this was all implemented. So we're finding ways of working through that.

And I think we need to keep the communication channels open because appropriate and good care planning and making sure that we're using the appropriate language, working within the appropriate philosophical frameworks that we do, and particularly with an AOD, that harm minimization framework, and where is the client at, rather than, where do we want them to be at any particular point in time, is really essential.

And that's all I've got to present at this point in time unless anyone had any questions. I'll leave it there. Thank you.

BEN: That's great. Thank you, Linda. And so just a reminder, if you do have any questions, please feel free to pop those in the chat, and we'll pose those to the presenters during our question-and-answer time. In the meantime, I will now hand over to Laura Fay.

LAURA FAY: Thank you. Hi, everyone. My name is Laura. I'm a team leader here in the Wide Bay. And I'm going to be presenting today on care planning, a programme that we're calling Prepare to Care.

So this slide just lists the fellow team leaders that have been assisting our service to move through this campaign. And I just wanted to make the point that we're team leaders in a regional service, a regional rural service, and we have responsibility for intake assessment, continuing care, older persons teams, as well as our Step-Up Step-Down facility.

So we've been working on a promotional campaign directed at consumers, carers, and families regarding their involvement in writing and reviewing their care plans. Our overall

concept was that increased education about care plans, what they're used for, and the consumer's vital role in making sure that they have one could contribute to the quality-of-care plans over time.

Since we were proposing that we engage consumers, we, of course, commenced direct consultation with two groups of residents from our Step-Up Step-Down facility in a written feedback format in a group, as well, and also sought the assistance of our service's consumer engagement facilitator and her consumer advisory group.

So we did this a couple of times. And the upcoming slides are the campaign posters as they exist now. There's one main poster and then some smaller, briefer speech bubbles with some targeted statements that were directed from some of their families and carers.

So I'd just like to mention a quick example of a feedback loop that we've already been a part of. Our original proposed campaign name was Dare to Care, which we thought rhymed quite nicely. But we had some feedback that this could be perceived as a bit of a challenge. So a group of our service users came up with Prepare to Care.

So this is just our main poster that I was speaking about, with some fairly key information about care plans. As you can see, it really just captures our most important message, which is that consumers should be involved in their care plan and, I guess, a really key one, which is that consumers can ask clinicians at any time about their care plan because they should indeed have one and be a part of making it.

This is an example of the feedback, just to show you. I apologise for it being hard to read. But it's simply just the posters in their very first examples. And people were able to write their feedback onto there.

The next few slides are just some of the briefer support posters that I mentioned. And as I said, these were generated fairly simply with some ideas directly received during the consultation process.

So finally, I just wanted to outline, I guess, where we're up to in our process and where to from here with the expected upcoming Comprehensive Care efforts. We realise that this is only one component of Comprehensive Care. And we're putting a lot of focus into finalising this iteration of the campaign.

Some of the questions we have been considering-- and I encourage you to consider if you'd like to do something similar for your service, is the time eternal question of how much consultation is enough. Is there actually a maximum amount? Because feedback is entirely subjective, as it should be. It's about people's individual journeys.

We need to open up these conversations to make sure our PDSA cycle can keep progressing and not stall. The overlay of governance and time frames needs to be considered, as well as an implementation strategy across many, many teams and service delivery types, potentially at varying levels of change readiness, I guess. Our intent to roll out consumer-led care reviews, as many of you are, across the service after our recent successful trial will also take the campaign promotions into account and hopefully open up more opportunity for discussion.

Thanks, everyone, for the opportunity to provide a quick snapshot into our services campaign. And I'd like to hand over to our next presenter. Thank you.

BEN: That's great. Thank you, Laura. I got some positive feedback from an attendee on those posters as well. So I'll hand over now to Zonia Weideman.

ZONIA WEIDEMAN: All right, great. Thank you, everybody. I'm assuming you can hear me, so I'll just go ahead.

BEN: We can hear you.

ZONIA WEIDEMAN: OK, I'm just waiting for the slides. So thank you for inviting West Moreton to present today at the care planning. It's been amazing to hear everybody's innovative ideas. And I'm hoping that we can incorporate some of this, especially Laura. Maybe yours is really innovative, and really great work on that.

So I'm Zonia. I'm the team leader for the Recovery, Resource, and Partnership Team in the Community and Acute Services, and I'm also the therapy lead for West Moreton. So it's not working that I could actually-- there we go. And there we go.

In 2018, West Moreton Community and Acute Services decided to complete an audit on care plans in CIMHA. This is because, even though we've got the KPI, and we know quantitatively how well we were doing, we really wanted to look qualitatively at the quality-of-care plans.

We also wanted to gain an insight into the utilisation of care plans by clinicians, assess consumer family and carer involvement in their care plans, and also check if people were or clinicians were using resources that's available to them when creating the care plans. Lara Bakes-Denman, our clinical initiatives coordinator, and Sonia Condon, West Moreton's CIMHA guru, is what title I have given her, has really assisted me with this audit.

Some study protocol was developed, and it was reviewed by the chair of our ethics committee within West Moreton and was deemed to constitute an audit of practise for the purposes of service development. And so the project was exempt from ethical review. We then looked at 54 consumer records across all the Community and Acute Services teams. And here are some of our key learnings.

So we were very proud that 98% of our outcome measures was completed and also that half of those, that we could see that the intervention was related to the outcome measure score. 60% of our care plans included individual therapeutic interventions.

Some of the opportunity for improvement was enhancing our clinicians' knowledge around what resources are available-- for example, some of the group therapies-- increase our consumer, family, and carer involvement, and also look at how we could specify our goals and also frequently review said goals.

So then we decided to do a training needs analysis. So we wanted to see what training and what resources we should have available for clinicians to increase or enhance the quality of their care plans.

Clinicians were asked a range of questions that you can see there-- so some of the enablers, some of the barriers of completing care plans, consumer engagement, what resources they require, and how confident they felt in completing their care plans. Clinicians were also asked to share any qualitative tips around completing care plans.

I've got a Costco cake there because we wanted to disclose that, yes, we bribed our teams to complete the training needs analysis. And no, we don't apologise, as we got a really good return rate.

So some of the key learnings from that is that clinicians obviously felt that a good rapport enables them to engage their consumers. That's not a surprise. But what they also said is that even if they have a good rapport, they don't necessarily have the time to then sit with a consumer and do good care planning.

They also felt that the team engagement within the MDT was a real enabler for them to enhance their care plans. But once again, they felt that they were not provided sufficient time within the MDT team meetings to actually speak about their care plans.

They also noted that the episodic nature of a consumer's illness does make it pretty hard to determine goals today because their goals might change tomorrow and the next day and the next day. And their clinicians' perspective was that the consumer's goals were sometimes unrealistic and could not be matched to their clinical goals.

So what we did with that information, then, is we've really provided a lot of training around the care planning process. And on the next slide, you'll be able to see that we've actually developed a flowchart to enhance clinicians' understanding of the care planning process.

We're also now using care plans as a referral document towards our group programmes and some of our discipline-specific clinics, for example, our OT clinic and our psychology clinic. And our biggest one is that we're also using it in the referral documentation towards the NGOs that we've got memorandum of understandings with.

We've worked really hard with our ACT, AMHU, and older persons MHU clinicians to improve the quality of their care plans. One of the biggest things we saw that worked well was providing examples of completed care plans and to illustrate how the document goals and strategies could be matched with the recovery goals of the consumers.

We provide a lot of training to all the new allied health staff that comes in-- our nursing grads. And I've provided training to the NGOs about how consistent care planning from the public health sector into the NGO world is really beneficial to the consumer.

Sonia has helped our Ipswich CCT team to implement the traffic light system, where it's flagged for planning to be created, reviewed, or overdue. We also now do randomised audits monthly. And we then provide that feedback directly to the case manager and to the team leader. And in our CCU, we now implement the goal attainment scale, which really helps us enhance the consumer's goals, their priorities, but also celebrate their progress within the CCU, which works very well.

So there you can see just the care plan process that we've developed. Maybe a little bit different from usual is that we've added that bit about resources, so making really sure that clinicians understand the resources that's available within West Moreton.

Where to from here is we are hoping to provide more goal setting training to clinicians, so especially looking at how we can match recovery goals to clinical goals. We're also developing supporting documentation around our case management approach within West Moreton. What we found is that really experienced clinicians and really experienced case managers struggle to impart that knowledge on new case managers.

And we've also gone to our Consumer and Carer Engagement Services and asked them to help us to enhance the consumer, family, and carer involvement in care planning. We really hope to embed the care planning process into everyday practise as the tool that we all work from, so that integral kind of tool.

I've included this slide because I think what's really important-- and I think a couple of other HHS have done this already-- but we've now developed a SharePoint site where we keep all our internal resources updated. That's done by our service integration coordinators.

One of the other things that the clinicians requested was some diagnostic guideline in terms of what they could potentially incorporate in their care planning process for consumers. And we do advertise the NICE guidelines. That Case Management Body of Knowledge is a case management education site.

And then there's heaps of other resources, for example, multicultural resources, where we've added those resources to our internal resources site with easy access-- so links this all there, and they can just click on it. So when they're doing care planning, it's quite easy for them to have a one-stop shop. Thank you.

BEN: That's great. Thank you very much for that, Zonia. I'll hand over now to Sandra Henderson for her presentation.

SANDRA HENDERSON: Hello, everybody, I'm Sandra Henderson. I'm the team leader in our Continuing Care Team in Mackay. It's clicking too far. I'm not feeling in control of the slides.

BEN: So Sandra, if you just want to click again on the slide.

SANDRA HENDERSON: Ah.

BEN: Yep. And if you right-click, you can go--

SANDRA HENDERSON: OK, too many clicks. OK, thank you.

BEN: No worries.

SANDRA HENDERSON: So anyway, that's where we work. That's where we're coming to you from. So we sort of accidentally got involved in the Brief Breakthrough Collaborative. But we really appreciated having that opportunity to think through care planning in a bit of a different way.

So our challenges are not really very different. They're something unique, but I've heard, through that project and also today, lots of similarities. So we have a very big team. Our team provide support to at least 370 clients at any one time over pretty big distance-- one hour rurally, one hour drive north, south, and west. So we have about 20 clinicians in our team. We have 1 and 1/2 psychiatrists. But actually, at the moment, we have no psychiatrists. So that adds to some of the dilemmas.

Most of our clinicians have less than two years' experience. We have a few that have got more than three. We have a really huge turnover. And as an example of that, in March, nearly half our team will be vacant or filled by an agency staff member.

So what we found that, on reflection, what we had been doing was we were just trying to do better with care planning. We didn't have any particular goal or end in sight. So it felt like we were just forever climbing a ladder. We didn't know where we were going.

So before we did this project, we weren't doing very well in the stats. And also, we've thought, these are things that don't work-- focusing on other things, saying it's too hard, mostly because of what people have been talking about today-- that genuine desire of the clinician to have the care plan developed with the client and their family participating and how very difficult that is, especially given our caseloads.

So we've also tried complaining in different forums about the format of the care plan. It's a bit clunky. There's that confusion that someone else has referred to today about the recovery versus the clinical goal. We've tried complaining about how many documents we have to fill in. And we tried just hoping it would get better. None of those things worked very well or made us feel very satisfied, actually, about the work that we were doing.

So then we participated in the project. What we have now is a better understanding of how it fits into that Comprehensive Care model. And the documents and the training that are available have been really, really useful, particularly because we have so many new staff.

We chose to just focus on getting it done. So rather than get caught up in it's not perfect-- it's not meaningful enough-- we actually decided to just do it. So we currently have a technique of allocating an hour a month where clinicians are encouraged to just get it done, so catch up on some care plans, do some research, do some personal learning. And we're also going to-- it's about three months since we did our initial start, so now we're going to do some more education about how to link in with outcomes and how it fits in with formulation.

What we've asked clinicians to do to stop that "I feel like I'm lying" is to actually write on the care plan who participated in it. This is just my plan based on what I know about my client. The client did participate. The family have been part of it. And so that's really helped people feel a bit more confident.

Also, our CIMHA information champions are distributing numbers each month. So that's giving clinicians who need that sort of information just some different prompting about how they're managing and who doesn't have a care plan.

Our current goal is just to meet 65% and stay there for six months. We achieved it on one of our last three months. So we're still getting there. But we feel like we now have a more stepped approach. And we know where the goal is. So it's easier to achieve.

Some comments from staff were that, actually, one of our staff members got an opportunity to work on the inpatient unit and was surprised to hear that lots of consumers, clients on the inpatient unit, actually had spoken to their community case manager. And they did know about what a care plan was. So that was pretty exciting.

Some people are noting that we're still using pretty broad, generic terms, which I heard in the beginning of the presentation aren't all that meaningful to the next clinician taking over or to the client if they see their care plan. Clinicians are saying, yep, I can document my care plan, even when the client isn't able or willing or available yet to participate. It's still a goal for that to happen.

Some people feel like their practise hasn't changed very much. And one of our newer case managers actually found that where a care plan had been documented was a really good starting place to have a conversation to get to know the consumer and quickly develop that rapport.

So in order to stay on target, what we want to do is keep trying to-- again, this is a not-defined goal, but we do have that goal of improving how we involve our clients, their families, and their supports in developing the care plan. We want to maintain the momentum that we've already developed. We're really clear that we need to integrate the skill and the process of formulation into the process of informing the care plans. And we want to have care plans that our clients can read and understand.

And I've been on a month-and-a-half leave. I just got the opportunity to go to clinical review yesterday. And it was really exciting to hear clinicians talking about how they had negotiated care plans with consumers and families and a much clearer way of being able to explain what they're doing with their clients and how long they might do that for. So anecdotally, it seems like it's working. Thank you.

BEN: Thank you very much for that, Sandra. And now I will hand over to our final presenter for today before question time, who is Sue Holley.

SUE HOLLEY: Thank you. Thanks to all the previous presenters. And thank you, everyone, for joining in today and for the opportunity for me to present a discipline-specific perspective to care planning.

So yes, my name is Sue Holley, and I'll be presenting work that is being implemented by the Mental Health Occupational Therapy Clinical Practise Collaborative. This group is a statewide group that supports evidence-based contemporary occupational therapy Practise across Queensland Health mental health, alcohol, and other drugs services.

So today, I'll be briefly showcasing The Occupational Therapy Care Planning Prompt Tool, with its associated resources and services guide, and The Occupational Therapy Provision of Service Guide for CIMHA. These tools have been developed and are now endorsed for use by occupational therapists working in mental health services across the state. And their aim is really to support the quality of the work that we do with our consumers.

And as a few people have mentioned-- formulation, today, as well-- these have actually been part of a whole package that we've looked at. And we've actually addressed the process of occupational formulation within the work that we've done as well, in terms of supporting OTs to bring that occupational focus to the formulation process as well.

So firstly-- there we are. Firstly, I'll be talking about the Care Planning Prompt Tool, which looks like this. So the purpose of the tool is that it's a prompting tool for occupational therapists to use to enhance care planning with consumers by aligning common clinical goals and the unique assessments, interventions, and resources that occupational therapists use to assist the consumer to achieve their individual recovery goals.

So the tool aims to support meaningful engagement in care planning for all consumers; to promote an occupational lens during care planning with consumers, their families, carers, and other supports; enable high-quality and comprehensive occupational therapy services across the state; and also to promote evidence-based contemporary occupational therapy Practise across all mental health services across Queensland Health.

Now, the Care Planning Prompt Tool is designed to be applicable across a range of mental health clinical settings, so everything from acute inpatient units to community case management settings, long-term rehabilitation environments, and so on. The current tool that we've developed is for the adult to older persons population.

We did initially try to develop a tool that would encompass the whole of the lifespan, but it became a little bit too big and unwieldy. So we decided to finalise the adult version first. And we'll actually be developing a specific tool for the child and youth population this year.

So the tool is definitely a prompt or a guide only. And to follow on from what was said earlier on in the presentation by Kat, it is definitely not the purpose of this tool to be a copy and paste. It's intended to be individualised for each consumer. But what the tool does-- it

outlines a range of potential clinical goals that may be of relevance to that particular consumer, suggested strategies, interventions, and involvement of other service providers, and also a range of resources that may be useful to consider.

What the tool aims to do is to prompt OTs to consider contemporary assessments, interventions, and resources that will enable them to promote occupation-based Practise and this, in turn, for the best possible outcome for the consumer. Now, the Care Planning Prompt Tool is accompanied by a resources and services guide, which I'll also show you a little bit later in the presentation.

So this is just a screenshot of the table of contents for the Care Planning Prompt Tool. So you'll be able to see from that the breadth of potential clinical goals that are covered within the tool. Now, the clinical goals are actually categorised into categories of occupation, person, and environment. And this was a deliberate decision to align these goals with core occupational therapy theory and processes.

So this is a screenshot of one page of the tool from the occupation section of the Care Planning Tool. You'll see, in the left-hand column there, there's an example of a clinical goal. This one's they're listed to do with education and leisure. The middle column then outlines a range of suggested strategies, interventions, potential involvement of other service providers that may be necessary to support the consumer to work on this goal. And then on the right-hand column, there'll be a list of potential resources that could be useful to keep in mind.

Now, it's not expected that every one of these suggested strategies or interventions will be appropriate for each consumer. But it provides a range of options based on best practise within occupational therapy for the OT and the consumer to consider and, obviously, then individualise to suit the consumer's needs.

So the Care Planning Prompt Tool is also accompanied by a resources and services guide. So we have developed a template that can be adapted by including relevant local resources and links as appropriate.

So this is a screenshot of the resources and services guide. So we've provided direct links to all the resources that are available statewide. And then we've put in a prompt for individual HHS to add in their own relevant local resources and services to customise this guide for their own use.

Now, very briefly, because this is part of a whole package of work that we've done related to comprehensive care, I would just like to also introduce you to the Occupational Therapy Provision of Service Guide.

BEN: Sorry to interrupt you, Sue. Just letting you know we're on seven minutes. So you'll have one minute left.

SUE HOLLEY: OK. All right, so again, this is a tool that's been developed to be applicable across a whole range of mental health settings. And it's really aiming to provide a consistent approach for occupational therapists to record their provisions of service.

The document has been divided into categories of assessments, strategies, interventions, involvement of other service providers, and care coordination. And again, it prompts OTs to consider contemporary assessments and interventions that promote occupation-based Practise.

Here is a screenshot of our provision of service guide, which shows how we've detailed the parent and potential child-level codes that are within CIMHA, accompanied that with the definitions that are there within the CIMHA business processes. And then we provide an outline of potential OT-specific and generic assessments-- or in the intervention section, interventions-- that you could actually record within those codes. Our aim is for us to be reporting what we're doing within our occupational therapy work in a more consistent way across the state.

So where to from here? As mentioned, these tools have been endorsed and are actually being rolled out to the mental health occupational therapy workforce across the state. We'll be running a whole education series to support OTs in their use.

The Care Planning Prompt Tool-- we're developing a child abuse-specific version this year. And obviously, we'll be looking at evaluation of these tools. So with the POS guide, particularly, we'll be looking at collecting data pre and post. With the Care Planning Tool, we'll be looking at auditing and looking at evaluating the quality of the care plans that the occupational therapy staff are developing with their consumers.

These resources are all now housed on our Mental Health OT Clinical Practise Collaborative SharePoint site and will be housed with the Comprehensive Care toolkit on Insight as well. And there's contact details for the collaborative, myself, and my cochair of the collaborative, Samantha Bicker. So you can email any of those addresses to get more information as well. Thank you.

JAMES: Thank you very much there, Sue, and to all the presenters. It's James here from Insight. And I'm with Dr. Neely, who is going to help us now with a Q&A panel time.

So we've got one question there, which the panellists may have seen come up in the chat. And that's to you, Sandra. So I'll give you a moment to have a look for your unmute button. Sandra, it's a question here about the project that you explained quite comprehensively. Will that be included in induction and onboarding for new team members?

SANDRA HENDERSON: Yes. Yes. I'm just thinking that that's what we really need to do now. I guess our division is just going through a bit of upheaval with that whole process. But it's been clear that that would be very helpful, some of those basics. I can't say any more about it. But yeah, it is a very good idea.

JAMES: No, that's great. Thanks very much, Sandra.

DARREN NEELY: Yeah, thank you Sandra. And now, given that we've got about three minutes left, what I might do just to finish off is, I guess, reflect on some of what we've covered today because we've covered a lot. And I really wanted to thank our presenters and also thank everyone that's linked in today.

I just wanted to firstly acknowledge the work that services are doing in this area. I think it's clear when you look at the data that, certainly, quantity is improving. And that's something that everyone is working on. I guess we've also heard some of the great initiatives that are happening around the state in terms of improving quality of care plans, which is, I guess, really the most important thing.

And a couple of reflections are the points that Robyn and Sandra made about having a conversation with someone and asking the question, what matters to you, as well as, what is it that would help you, is really important and, I guess, gets back to that point of engaging

someone in a discussion and looking at this collaboratively, with the aim of creating something that is individualised.

And I guess that goes back to Kat's comment about some care plans and what Kat is observed in care plans, just really thinking about, what is it for this person that is going to help? And not only from a team perspective and the clinical goals the team have, but crucially, supporting someone with their recovery, their personal goals.

So listen, we probably are about to run out of time. So again, thank you all for linking in. And Ben or James, do you have any final matters to raise?

BEN: Thank you very much for that, Darren. Just here to remind everyone that the next webinar on care review will be on the 3rd of March at 11:30, from 11:30 to 12:30. And if people could please remember to take a moment to complete the survey by the link that will be in the chat and as you exit the meeting.

Thank you, everybody, for your attendance today. And we hope you enjoy the rest of your week.