

# The In Practice Times

For practice nurses and practice staff. For more detailed information see the In Practice chapter on [www.nrdgp.org.au](http://www.nrdgp.org.au)

April 2005

## Practically a care plan

*In a special prequel to our April network meeting, this month's IPT is centred around a case study written by Therese Greenlees for an earlier edition of GPSpeak.*

### Care plans & the world of general practice

It's time for you to be introduced to our patient, Doris Brown. Doris is a 76 year-old woman who recently moved to the area to be closer to her daughter. She presented to the surgery overweight, supported by a walking stick and carrying a letter from her previous GP, which confirmed a diagnosis of diabetes. After consultation, the GP gains the patient's consent for a health assessment to be performed in her home, to provide a complete picture of her needs, and the practice nurse visits Doris the following week.

### Needs assessment

Doris returns to the surgery following the home assessment, and the GP discusses the findings with her. There is concern for Doris's safety at home as there are no railings in the bathroom or on the outside stairs, she needs help to improve her diet, and she appears to take a number of non-prescribed medications. Doris certainly meets the criteria for a care plan, given that her chronic condition and complex needs require coordination of her multi-disciplinary care, so the GP gains her consent. The GP now meets with the practice nurse to discuss the patient's needs and current care providers, and the practice nurse writes up the care plan.

At this point it is important to note that a health assessment is not a pre-requisite for a care plan, the assessment of the patient's needs can be determined over one or a number of consultations. It is also not necessary for health assessments to be performed in the patient's home. They can just as easily be performed at the surgery, either with or without a practice nurse, although it does make it a little harder to determine the patient's living conditions.

Doris already has an appointment to see a diabetic educator and dietician at the

community health centre, and this will fulfil the first goals of the care plan: to improve Doris's understanding and self-management of diabetes, to improve her diet and exercise routine, and to reduce her weight. As the practice nurse will provide ongoing foot examinations, education and monitoring of Doris's glucometer readings, blood pressure and weight loss, he or she may also be included as a care provider – remember to be in the care plan, a provider must give separate and ongoing care.

### Care plans and allied health

Doris doesn't know of an occupational therapist, so as with the other providers, the nurse contacts an OT, and obtains her agreement to be involved and provide a written report. As the OT works privately, the GP will use an HIC specific referral to ensure Doris receives a rebate for the two visits required to assess and improve her home safety, leaving three referrals for the care plan review in three months. The care plan is completed after the nurse determines the GP will undertake the goal of reducing the risk of complications by monitoring Doris's condition and referring her to a podiatrist, ophthalmologist or physician as needed.

At their next appointment, the GP discusses the care plan with Doris, adding a final goal of reviewing Doris's prescribed and non-prescribed medication by referring her for a home medicine review (HMR). The pharmacist also becomes a provider. Doris agrees to the goals and is given a copy of the care plan, along with all the other providers, as well as a copy kept on file. The practice staff are instructed to claim item 720 and the nurse enters Doris into the recall system for three months time, checking that all the reports from the providers have been received before making an appointment for the review.

### Help and support

So where do you access services and sup-

port for your care plan patients? Before you start, grab yourself a folder where you can keep telephone listings, information, and resources all in one place. Carelink is a fabulous resource when you are trying to access help for the aged or those with disabilities (ph: 1800 052 222) and it's worth scanning the myriad of faxes and letters that enter the practice for patient clinics, support groups, and home help. Community Health can also be a wealth of information, as is the internet, and networking with others who write care plans is invaluable. And remember, as always, if you have any questions, please contact one of your practice liaison officers on 6622 4453.

~ Therese Greenlees, Practice Liaison Officer

## PN Network Meeting

### Practically a Care Plan

Thurs 28 April  
6.00 for 6.30pm

Speakers: Kirsty Nicholls  
& Therese Greenlees

Cost: \$22.00

To book ph 6622 4453.



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