

Community Healthcare East

INDIVIDUAL RECOVERY CARE PLAN

Please Affix
Patient Label Here

Health Service Executive Community Healthcare East Mental Health Services INDIVIDUAL RECOVERY CARE PLANNING PATHWAY

- On Admission

Admitting Clinician & Available MDTs with Service User

1. Initial assessment on admission to identify the needs and immediate risk

Complete

Preliminary/Initial Care Plan to address the immediate needs/risks of the resident (p 2-6)

2 - First MDT Meeting

Service User Consultant / NCHD Nurse / Psychologist / OT Social Worker / CNS Family-Carer / Advocate

Comprehensive assessment within 7 days of admission

- 1) Medical, psychiatric & psychosocial
- 2) Medication history and current medication
- 3) Current physical health assessment
- 4) Detailed risk assessment

Develop Individual Recovery Care Plan

- a) Mental health/emotional needs identified
- b) Physical health needs identified
- c) Spiritual needs
- d) Socio-economical needs
- e) Review service user views/expectations
- f) Review risk identified & risk management plan
- g) Review discharge plan
- h) Educational needs (for children)

3 - Subsequent MDT **ICP Review Meetings**

Service User Consultant / NCHD Nurse / Psychologist / OT Social Worker / CNS Family-Carer / Advocate

Weekly Review & Update ICP

- a) Review outstanding issues from initial care plan
- b) Review service user views/expectations
- c) Review risk assessment & risk management plan
- d) Review discharge plan
- e) Update care plan

4 - Pre-Discharge Risk **Assessment**

Service User Consultant / NCHD Nurse / Psychologist / OT Social Worker / CNS Family-Carer / Advocate

Complete

Pre-Discharge Risk Assessment

& Risk Management Plan

5 - Discharge Planning

Service User Consultant / NCHD Nurse / Psychologist / OT Social Worker / CNS Family-Carer / Advocate

MDT - ICP DISCHARGE PLAN

- Must identified the resources required 1.
- Must be filed in the service user clinical file 2. 3.
- Will be audited on a quarterly basis



INDIVIDUAL RECOVERY CARE PLAN

Health Service Executive Community Healthcare East Mental Health Services

Please Affix **Patient Label Here**

Unit:	
Date of Current Admission:	
ICD Classification on Admission:	

	MULTIDISCIPLINARY	TEAM MEMBERS
Consultant:	Registrar:	Key Worker:
Nurse:	Occupational Therapist:	смни:
Social Worker:	Psychologist:	Dietician
Others:		
NEXT OF KIN		
Name:		Relationship:
Address:		
Contact No.:		Permission to Contact: Yes No No
GP DETAILS		
Name: Address:		
PHARMACY DETA	LS	-
Name:		Contact No.:

INDEX OF NEEDS

No.	Need	No.	Need
1	Mental Health	9	Engagement includes insight, medication management, commitment to treatment plan
2	Physical Health	10	Accommodation
3	Diet / Nutrition	11	Safety includes safety to others and self
4	Self-Care / ADLs	12	Support Network includes family, social and professional relationships
5	Cognitive include communication, memory/concentration	13	Spiritual
6	Occupational needs include vocational and leisure needs	14	Sexual needs
7	Financial issues include debt management, benefits, etc.	15	Educational/Vocational
8	Substance Misuse	16	Others:

PRELIMINARY INDIVIDUAL RECOVERY CARE PLAN

To Be Completed
On admission By the Admitting Clinician

RISK ASSESSMENT

ADMISSION

Risk Area				
Risk of self-harm & risk of suicide: (Specify- suicidal ideation, plans or inter	nt)	Yes	No	N/A
Identified risk:				
Risk Management Plan:				
Risk of violence/challenging behaviour: (For example; abusive language, exviolent thoughts, conformational or intimidating behaviour)	xpressing	Yes	No	N/A
Identified risk:				
Risk Management Plan:				
Personal vulnerability (For example; Exploitation, risk poor communication o	r social	Yes	No	N/A
isolation)		. • •		
Identified risk:				
Risk Management Plan:				
Personal risk to staff:(For example: Special infection hazard, vexatious intera	action, resistive	Yes	No	N/A
or suspicious to staff)				
Identified risk:				
Risk Management Plan:				
Nisk Management Flan.				
Medical, Substance misuse, Environmental & any other risks:		Yes	No	N/A
Identified risk:		100	110	14// (
Risk Management Plan:				
Name of Risk Assessor: Signa	ature:	Date		



"PRELIMINARY" INDIVIDUAL RECOVERY CARE PLAN

To be completed on admission by admitting clinician

	Please Affix Patient Label Here		Unit:	
			Date:	
ļ		J	Time:	
			Completed By:	
Se	vice User in Attendance: Yes	☐ No ☐ If No, why?		
Init	al Observation Required:			
Gei	neral (Hourly) Close	Observation (30 minutes)	Special (Const	ant) 🗌
Rat	ionale:			
Rat	ionale:			
Da	y Clothes Night Clothes	. 🗆		
Ra	tionale:			
Vis	iting Restrictions: Yes	No 🗌		
	tionale:			

No.	Needs Identified		De	esired Goals	Action (Treatment	& Care)	Resource/Responsible Person
ICP e	xplained to Service User:	Yes 🗌	No 🗌	If No, why?			
Servi	ce User agrees with content of ICP?	Yes 🗌	No 🗌				
Сору	of ICP offered to Service User:	Yes 🗌	No 🗌	If No, why?			
					ı		
Signe	d (on behalf of MDT):			Date:		Next ICP Rev	view Date
Com-!	an Hann Cimmatura			Data			
Servi	ce User Signature:			Date:	L		

Initial Multidisciplinary Team Individual Recovery Care Plan Meeting

INDEX OF NEEDS

No.	Need	No.	Need
1	Mental Health	9	Engagement includes insight, medication management, commitment to treatment plan
2	Physical Health	10	Accommodation
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7	Financial issues include debt management, benefits, etc.	15	Educational/Vocational
8	Substance Misuse	16	

PRE-MDT REVIEW 1

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 1
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 2

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 2
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 3

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 3
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 4

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 4
Date of MDT Meeting:
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 5

Inerapeutic Engagement Session (10 Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 5
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 6

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S)
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 6
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 7

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S)
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 7
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 8

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S)
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 8
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 9

Therapeutic Engagement Session (To Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S)
Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 9
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) ☐ Close Observation (30 Minutes) ☐ Special (Consultant) ☐
Service User Agrees with Content of ICP? Yes No No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

PRE-MDT REVIEW 10

Inerapeutic Engagement Session (10 Be Completed With Service User)
How you are feeling?
And what do you feel you have achieved this week?
What goals do you hope to achieve next week?
Weekly Therapeutic Intervention(S) Recreational Activities and Therapeutic Services
Others:
Behaviour & Current Mental Status
Completed with Service User Yes No If No, why?
Key Worker Signature: Date:
ICP MDT REVIEW 10
Date of MDT Meeting:
Present at MDT Meeting (Please tick): Consultant Registrar Key Worker Nurse CMHN OT Intern Psychologist Social Worker Dietician Others
Service User: Yes No If No, why?
Significant Risks Identified:
Estimated Discharge Date:
Updated Leave Status: Accompanied Unaccompanied
Day Clothes Night Clothes Rationale:
Visiting Restrictions: Yes No Rationale:
Observation Level Required: General (Hourly) Close Observation (30 Minutes) Special (Consultant)
Service User Agrees with Content of ICP? Yes No If No, why?
Has Service User Been Offered a copy of ICP? Yes No No If No, why?
Service User Signature: If No, why?

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:
Date	Index of Need No.		NEEDS IDENTIFIED		GOAL
		Action (Treatment & Care)		Resources/Responsible MDT Member
				=	NOT 01
Date		Weekly / Six month	ly Needs Review & Progres	s Evaluation	MDT Signature

NAME: _		DOB:	MRN No.:	MDT Name:	Sig	nature:
Date	Index of Need No.		NEEDS IDENTIFIED		GOA	L
		Action ((Treatment & Care)		Resou	rces/Responsible MDT Member
Date		Weekly / Six month	ly Needs Review & Progress	s Evaluation		MDT Signature

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)		Resources/Responsible MDT M	ember
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	1	NEEDS IDENTIFIED		GOAL	
		Action (1	Freatment & Care)		Resources/Responsible MDT	Member
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)		Resources/Responsible MDT M	ember
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:
Date	Index of Need No.		NEEDS IDENTIFIED		GOAL
		Action (Treatment & Care)		Resources/Responsible MDT Member
Date		Weekly / Six month	ly Needs Review & Progress	s Evaluation	MDT Signature

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)	·	Resources/Responsible MDT M	Member
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.		NEEDS IDENTIFIED		GOAL	
		Action (Treatment & Care)		Resources/Responsible MDT Member	
	•					
Date		Weekly / Six month	ly Needs Review & Progres	s Evaluation	MDT Signature	

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	NEE	DS IDENTIFIED		GOAL	
		Action (Trea	tment & Care)		Resources/Responsible MDT Member	
Dete		Mankley Circums within	Needs Daview 9 Dresses	on Fredricking	MDT Circusture	
Date			needs Review & Progres	SS Evaluation	MDT Signature	
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		Weekly / SIX Monthly 1				
		Weekly / SIX Monthly 1				
		Weekiy / Six monthly 1				

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)		Resources/Responsible MDT M	ember
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	NEEDS IDENTIFIED		GOAL	
		Action (T	Freatment & Care)	·	Resources/Responsible MDT	Member
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)		Resources/Responsible MDT M	ember
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	1	NEEDS IDENTIFIED		GOAL	
		Action (1	Freatment & Care)		Resources/Responsible MDT	Member
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

NAME: _		DOB:	MRN No.:	MDT Name:	 Signature:
Date	Index of Need No.		NEEDS IDENTIFIED		GOAL
		Action	(Treatment & Care)	,	Resources/Responsible MDT Member
Date		Weekly / Six month	nly Needs Review & Progres	s Evaluation	MDT Signature

NAME: _		DOB:	MRN No.:	MDT Name:	Signature:	
Date	Index of Need No.	N	IEEDS IDENTIFIED		GOAL	
		Action (T	reatment & Care)		Resources/Responsible MDT M	ember
Date		Wookly / Six monthl	y Needs Review & Progress	Evaluation	MDT Signature	
Date		weekly / Six months	y Needs Review & Progress	Evaluation	MDT Signature	
	1					

Discharge Planning & Follow-Up

Please Affix
Patient Label Here

RISK ASSESSMENT

Pre Discharge Risk assessment

Risk Area			
Risk of self-harm & risk of suicide: (Specify- suicidal ideation, plans or intent)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
	ı	ı	T
Risk of violence/challenging behaviour:(For example; abusive language, expressing	Yes	No	N/A
violent thoughts, conformational or intimidating behaviour) Identified risk:			
Tuertineu risk.			
Risk Management Plan:			
Personal vulnerability (For example; Exploitation, risk poor communication or social	Yes	No	N/A
isolation)	103	140	14// (
Identified risk:			<u>l</u>
D. I M DI			
Risk Management Plan:			
Professional risk:(For example: Special infection hazard, vexatious interaction, resistive or	Yes	No	N/A
suspicious to staff)			
Identified risk:			
Risk Management Plan:			
Medical, Substance misuse, Environmental & any other risks:	Yes	No	N/A
Identified risk:	100	110	14/71
Diek Managament Dlan.			
Risk Management Plan:			



RECOVERY CARE PLAN ON DISCHARGE

Health Service Executive Community Healthcare East Mental Health Services

Please Affix Patient Label Here		Unit:		
Patient Laber nere		Date of Current Admiss	ion:	
			ew:	
		Pre-Discharge Meeting Date:		
		ICD 10 Classification on Dischar	ge:	
DISCHARGE TO:				
Home Hostel	Sheltered Accommoda	ation		
Other				
Accompanied by:				
Family Friend	Advocate			
Other				
Full Discharge Address:				
Telephone No.:				
REFERRALS TO:				
Community Mental Health Nurse	Social Worker	Homecare Team	ОТ 🗌	
Day Hospital OPD	Day Centre	Psychology	GP 🗌	
Other				
Multidisciplinary Team Nam	es / Contact Numbe	rs		
Consultant:		Contingency contact details:		
Community Mental Health Nurse	/ Day Hospital Nurse:			
Psychologist:				
Registrar:				
OT:				
Social worker:				



RECOVERY CARE PLAN ON DISCHARGE Health Service Executive Community Healthcare East Mental Health Services

IDENTIFIED NEEDS AT PRE-DISCHARGE MEETING

	Needs	Yes/No	Actions/Interventions
1	Mental Health		
2	Physical Health		
3	Diet / Nutrition		
4	Self-Care / ADLs		
5	Cognitive		
6	Occupational		
7	Financial issues.		
8	Substance Misuse		
9	Engagement		
10	Accommodation		
11	Safety		
12	Support Network		
13	Spiritual		
14	Sexual needs		
15	Educational/Vocational		
16	Others		
SUM	MARY OF RECOVERY CARE PLAN (Including ear	dy warning signs of relapse and crisis intervention plan)
	Appointment Date:		
Servi	ce User agrees with content of Recovery	/ Care Plan?	Yes
Сору	of Recovery Care Plan offered to Service	e User:	Yes
Comr	nunication to GP Regarding Discharge		Yes
Signe	ed (on behalf of MDT):		Date:
Servi	ce User Signature:		Date:



GOOD PRACTICE DISCHARGE CHECKLIST

Health Service Executive
Community Healthcare East Mental Health Services

CHECKLIST	YES	NO	N/A
Has the discharge been recorded in the clinical file?			
Has the discharge been recorded in the ICP?			
Has the Service User been given details of community follow up?			
Has the Service User been given information and contact details of support services / Voluntary Organisations?			
Has the Service User been given their relapse prevention plan as per ICP?			
Has the Service User's GP been informed of the discharge date and plan?			
Has the Service User been given a prescription and information on their medications?			
Has the Service User collected all property and valuables as listed?			
Has a discharge questionnaire been offered to the Service User?			
	_		
Signed (on behalf of MDT):		Date:	
Service User Signature	ı)ate:	