Guidance document on individual care planning, mental health services

Mental Health Commission

Guidance Document on Individual Care Planning Mental Health Services

MENTAL HEALTH COMMISSION - GUIDANCE DOCUMENT ON INDIVIDUAL CARE PLANNING MENTAL HEALTH SERVICES

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April 2012

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Table of Contents

Appendices

1. Purpose and Background

This guidance document has come about as a result of the recommendations from the *Final Report of an Independent Evaluation of the National Mental Health Services Collaborative on Individual Care Planning* (2011). Recommendation 4 of point 5.1 of this report recommended that the Mental Health Commission:

> *"Announce the intention, within a feasible period (say a year) of publishing a suite of national mandatory care planning documentation, with variants for different types of services. .....The value of the templates would be increased if they were published alongside brief guidance and examples of what a good plan might look like."*

It is intended that this document will assist service users and health care providers to devise individual care plans for all service users of mental health services in Ireland and to ensure that the requirements of Articles 15 and 16 of Statutory Instrument No 551, (Government of Ireland, 2006), are met (hereafter referred to as the regulations).

In addition to the above, the involvement of the individual in his or her treatment and care is a significant cornerstone of the Mental Health Act, 2001. Actively working with the service user to complete his/her care plan is a logical and meaningful means of ensuring the involvement of the service user.

An individual care plan, as defined by *the regulations, is:*

> *"a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation."*

Article 15 of *the regulations* states*:*

> *"The registered proprietor shall ensure that each resident has an individual care plan."*

Article 16 of *the regulations* states:

> *"(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan."*
>
> *"(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident."*

When endeavouring to ensure that Articles 15 and 16 of ***the regulations*** are met, it is necessary to understand fully the care planning process.

The Individual Care Plan Components include:

- A documented set of goals
- Regular review and update of the plan by the resident's multidisciplinary team
- Consultation with each resident in so far as is practicable
- Specification of treatment and care required in accordance with best practice
- Identification of the necessary resources
- Specification of appropriate goals
- Records being kept in one composite set of documentation
- Consideration of education requirements in the case of a child.

Inspector of Mental Health Services, 2011

If each of the above components are fulfilled the mental health service provider will be fully compliant with Article 15 of the Mental Health Act 2001, (Approved Centres) Regulations 2006.

Compliance with Article 15 is, however, not the only benefit or impetus for completion of a care plan.

Government policy *'A Vision for Change'* (Department of Health & Children, 2006) advocates the need for consultation with users and carers, in order to construct a comprehensive care plan. It further adds that care plans should be written and agreed between all parties, and includes a time frame, goals and aims of the user, the strategies and resources to achieve these outcomes and clear criteria for assessing outcome and user satisfaction.

In addition to the above legislative and policy requirements, the *"Quality Framework for Mental Health Services in Ireland"* published by the Mental Health Commission in 2007 provides a clear framework of standards which providers of mental health services are expected to meet. This includes Standard 1:1:

"Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multi-disciplinary team, i.e. a key-worker".

The importance of this standard has been carried through the National Mental Health Services Collaborative (NMHSC) on individual care planning; where a stated objective of this group was "to attain standard 1.1 of the *Quality Framework* and the relevant criteria for standards 1.2, 1.3, 1.5, 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 4.2, 6.1, 7.3, 7.4 and 8.1".

To illustrate the relevance of these criteria to this guidance document the standards are listed, overleaf as follows:

Table 1:

Quality Framework for Mental Health Services in Ireland Standards Relevant To Care Planning

Theme	Standard Code	Standard
1. Provision of a holistic, seamless service and the full continuum of care provided by a multidisciplinary team.	1.2	Each service user experiences a planned entrance to and exit from every part of a mental health service.
	1.3	Each service user receives mental health care and treatment from a community based service that addresses the person's changing needs at various stages in the course of his/her illness.
	1.5	Therapeutic services and programmes to address the needs of service users are provided.
2. Respectful and empathetic relationships are required between people using the mental health services and those providing them.	2.1	Service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences.
	2.2	Service users rights are respected and upheld.
3. An empowering approach to service delivery is beneficial to both people using the service and those providing it.	3.1	Service users are facilitated to be actively involved in their own care and treatment through the provision of information.
	3.2	Service users are empowered regarding their own care and treatment by exercising choice, rights and informed consent.
	3.3	Peer support/advocacy is available to service users.
	3.4	A clear accessible mechanism for participation in the delivery of mental health services is available to service users.
	3.5	Service users experience a recovery-focussed approach to treatment and care.
4. A quality physical environment that promotes good health and upholds the security and safety of service users.	4.2	Service users in residential or day settings receive a well-balanced nutritious diet.

6. Family/chosen advocate involvement and support.	6.1	Families, parents and carers are empowered as team members, receiving information, advice and support as appropriate.
7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service.	7.3	Learning and using proven quality and safety methods underpins the delivery of a mental health service.
	7.4	The care and treatment provided by the mental health service is outcome-focussed.
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services.	8.1	The mental health service is delivered in accordance with evidence-based codes of practice, policies and protocols.

Furthermore, the Inspector of Mental Health Services suggests ten reasons to implement care planning, as follows:

1. Respect for the patient
2. Good practice
3. Better patient co-operation
4. Good communication with the family, helping to involve them in the patient's care
5. Enhancing communication between the multi-disciplinary team and different shifts
6. Medico-legal defence
7. Improves measurement of progress towards all goals
8. Clearer identification and analysis of problems
9. Easier to audit care and treatment provided
10. It is legally required to do so.

In summary, a best practice perspective nationally and internationally requires that each user of mental health services should have an individualised care plan. The *Mental Health Act* 2001, (Approved Centres) Regulations 2006, also places a statutory obligation on services to ensure that residents within approved centres have an individual care plan.

2. Context

Traditionally, each discipline within mental health services completed their own discipline specific care plan and no one multi-disciplinary care plan existed. Today, ***the regulations*** require that an individualised composite document is completed by the multi-disciplinary team in consultation with the service user. The care plan exists for each service user to assist with recovery and to facilitate the service user, the providers of services, the family member or advocate, to work towards the desired outcome.

Criterion 1.1.3 of the *Quality Framework* (2007) advocates that the care and treatment plan should reflect the assessed needs of the service user, not from any one professional group but from the perspective of the multidisciplinary team. Care and treatment should be developed, implemented and reviewed in a timely manner, signed by the multidisciplinary team member who is the allocated key-worker and the service user, (if the service user chooses not to sign the care plan a note should be made of this refusal), and a copy of the care plan kept by the service user unless there is a documented reason for not doing so (Mental Health Commission, 2007). This criterion also reflects the ambition of *"A Vision for Change"* (Department of Health & Children, 2006), which proposes a person centred treatment approach, through an integrated care plan, evolved and agreed upon with service users and carers.

Contemporary views would require that for the care plan to be a dynamic, positive document the concept of *"Recovery"* should form the basis of its construct. Since the 1980s, momentum has been given to the concept of recovery oriented mental health services. It is acknowledged that the person's journey through mental illness is not always destined to result in on-going deterioration and loss of skills but that the person can recover and have a meaningful life (Higgins, 2008).

There is now internationally a real desire to embed the concept of recovery into all aspects of mental health service delivery and to place recovery at "the heart of all that we do", (Devon Recovery Group, 2008). The Mental Health Commission, 2007, identified in the *Quality Framework* (Standard 3.5), the need for a recovery-focussed approach to the treatment and care of service users.

Care plans are a crucial part of supporting and helping the process of recovery. They should not be distinct from the daily provision of care. They are a key mechanism by which a person's individual care and treatment can be developed, documented and shared with all those who are involved. Care plans provide a participatory framework for agreeing and reviewing the benefits of a given programme of treatment and care with an individual in the context of his or her recovery.

A variety of care plan templates exist and there is no requirement for one template to be implemented in all settings[1]. The care plan template is but a means of recording the plan clearly. The care planning process itself must meet the required criteria and be meaningful, regardless of the template being used.

A good care plan requires the care planning process to be an evolving process facilitating adaptation and change. It must include a pre-scheduled evaluation of the plan in collaboration with the service user. Any adjustments to the care plan should be agreed and documented and signed by a member of the MDT and the service user. Unscheduled evaluation of a care plan may also be required at times.

The benefits of a care plan include:

- The identification of problems and setting of realistic goals that can then be worked towards and achieved
- Service user and providers become more focussed on the individual's needs
- Service users become more involved in the care planning process, thus fostering a sense of commitment and responsibility in achieving their personal health gain and social gain
- Continuity of care among the relevant disciplines becomes more streamlined.

NMHSC Learning Set (2011)

The care plan should reflect the service user's needs and wishes, and is about both the more immediate concerns of care and safety and support with progress towards recovery.

[1] A range of templates from services nationally, are available for use/ adaptation on the Mental Health Commission website, www.mhcirl.ie.

According to the Mental Welfare Commission of Scotland (2009) best practice points with regard to care planning include:

- The person being involved from the beginning
- An understanding of the person's communication style/needs
- Using advance statements if they exist (encouraging the development of such statements if they don't exist)
- Involvement of the advocate/carer
- Ensuring the person understands the care planning process and the care planning discussion
- Recording the person's views including his or her met and unmet needs
- Availability of the care plan in a format that is meaningful to the person
- The person having a copy of his or her care plan, or knowing where it is kept and having access to it
- The language used being easy to understand
- The care plan containing up to date contact details for all involved, including telephone numbers
- The proposed treatments and services being available to the person (in a timely fashion)
- If there are unmet needs these are recorded and proposals to remedy them documented
- The plan clearly identifying those elements that are to be provided on a compulsory basis (when applicable) and those with the consent of the person
- Any recorded matters are clearly identified and the actions required clearly timetabled
- Clearly identified timescales for review and evidence of this occurring
- Evidence that outcomes are monitored and care and treatment adjusted accordingly
- Changes are documented and a system is in place to ensure that the most up to date care plan is available to the care team and to the person themselves
- Risk assessments and risk management plans regularly reviewed and updated
- Crisis plans, or out of hours contact arrangements, clearly documented
- The care plan makes reference to social, recreational and spiritual needs as well as to treatment and community care needs
- Physical health care needs documented where appropriate
- Named persons/carers/independent advocates and others, as well as professionals, that have been involved in the preparation of the care plan
- Evidence of the issues that are important to the individual being taken into account.

(Mental Welfare Commission for Scotland, 2009)

3. Roles:

Many individuals will have a role in the development of care plans. The roles may include those of: service user, key worker, consultant psychiatrist, mental health nurse, psychologist, occupational therapist, social worker, and possibly others. Often this will depend on what members of the multi-disciplinary team exist in the service. The key roles in care plan development are that of the service user, the key-worker and the mental health service itself. It is appropriate to briefly consider what each of these key roles involves.

Service user:

The Mental Health Commission document *"Teamwork within Mental Health Services in Ireland"* (2010) details the role of the service user within the mental health team and refers to Slade (2009) when emphasising the need for service users to be recognised as experts in taking an active involvement in their own care.

If mental health services are to ensure that the needs of the service user are paramount then being true partners in the mental health team is essential. This self-advocacy will increase the opportunities for engagement and decision making. The service user acting as a self-advocate must be facilitated to work in partnership with the key-worker to develop his/her care plan. If self-advocacy is not possible then independent peer advocacy should be sought.

Key-worker:

The appointment of a key-worker to each service user is required under Standard 1.1 of the *Quality Framework* (2007) and the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009).

The key-worker role is also identified in the *Quality Framework* (2007) in Standard 1:1:

> *"Each service user has an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs and is co-ordinated by a designated member of the multi-disciplinary team, i.e. a key-worker"* (pg 19).

The *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009) requires a key-worker system to be in place; the key-worker to be assigned as soon as possible after admission, the name of the key-worker to be documented in the resident's clinical file and the person selected as the key-worker to be the most appropriate person to be the service user's key-worker.

According to the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009) the role and responsibilities of the key-worker are as follows.

Key-worker role:

- Make him/herself known to the service user
- Make him/herself known to his/her family/carer/advocate (with consent).

Key-worker responsibilities:

- Coordinating of all stages of the service user's stay
- Serving as a point of contact for the service user
- Serving as a point of contact for family/carer/advocate
- Provide the service user and others with information
- Informing the service user of the likely inpatient process/steps
- Working with other members of the MDT to ensure that liaison with relevant agencies takes place
- Co-ordinating all stages of the service user's transfer to another facility
- Co-ordinating the discharge process with team and other relevant agencies
- Ensuring that all relevant documentation has been completed.

The Mental Health Service:

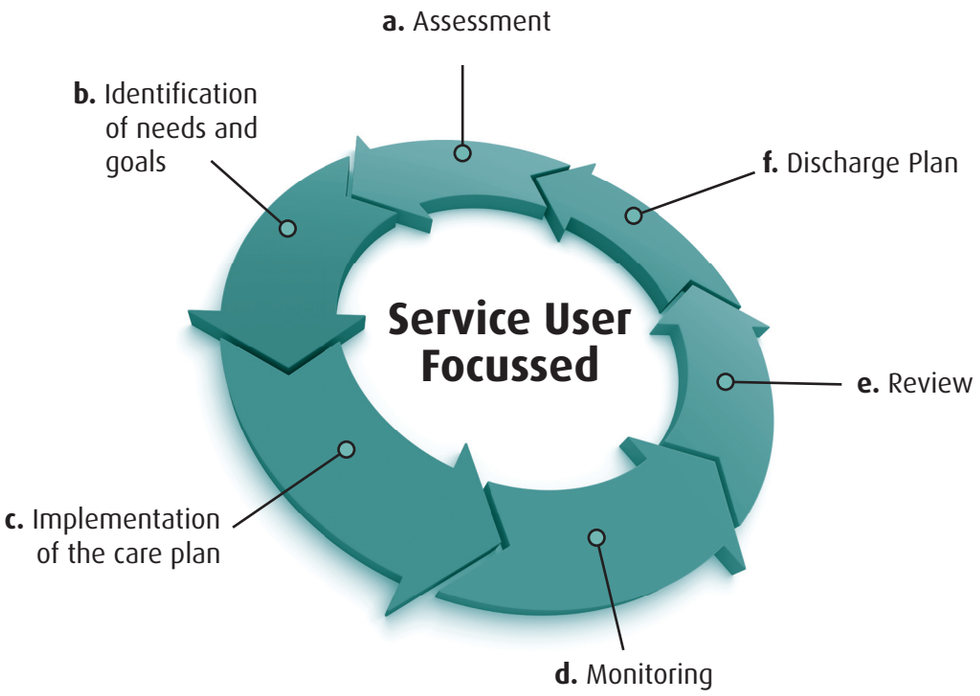
The service should ensure that:

- A system of care planning is agreed upon and implemented
- Staff and service users receive necessary training and information on care planning
- A scheduled process of audit is applied to care planning and improvements are made as a result of such audits
- The care planner receives adequate training and experience
- The care planner has access to up to date evidence and information including a directory of potential resources.

4. Practical Application of Individual Care Planning:

Care planning can be viewed as a developing record of a person's care process, created as a collaborative document, between the individual and the professionals involved. It is a flexible document and will consider a range of issues for the person. The key components are illustrated in the following diagram.

Diagram 1 – The Care Planning Process



The objective of care planning is to identify service user needs, address how the person lives with the condition and assist all supporting that service user to have the information they need; to help ensure the service user receives the care which they consider best meets their needs.

A prerequisite to care planning is the fundamental component of service user involvement. The service user must be a partner in his/her own mental health care. The care plan belongs to the person accessing services. If services are to deliver a recovery-oriented service, practice should always be directed towards facilitation or resumption of the person's own decision making in all aspects of his/her life.

Where a person is unable to represent their own views at any given time during their contact with services, the onus is on the service to ensure the person's views are properly represented in all decision making processes. ***The more involved a service user is in the care planning process the more likely s/he is to be committed to the outcome of the process.*** Collaborative partnership with service users is central to recovery and creates a relationship that is strengths focused and based on openness, equality, power sharing and reciprocity (Shepherd, Boardman & Slade, 2008).

The active involvement of the service user means that the remaining components of care planning i.e. assessment, goal and need identification, implementation, monitoring, review and discharge planning are valid and meaningful processes.

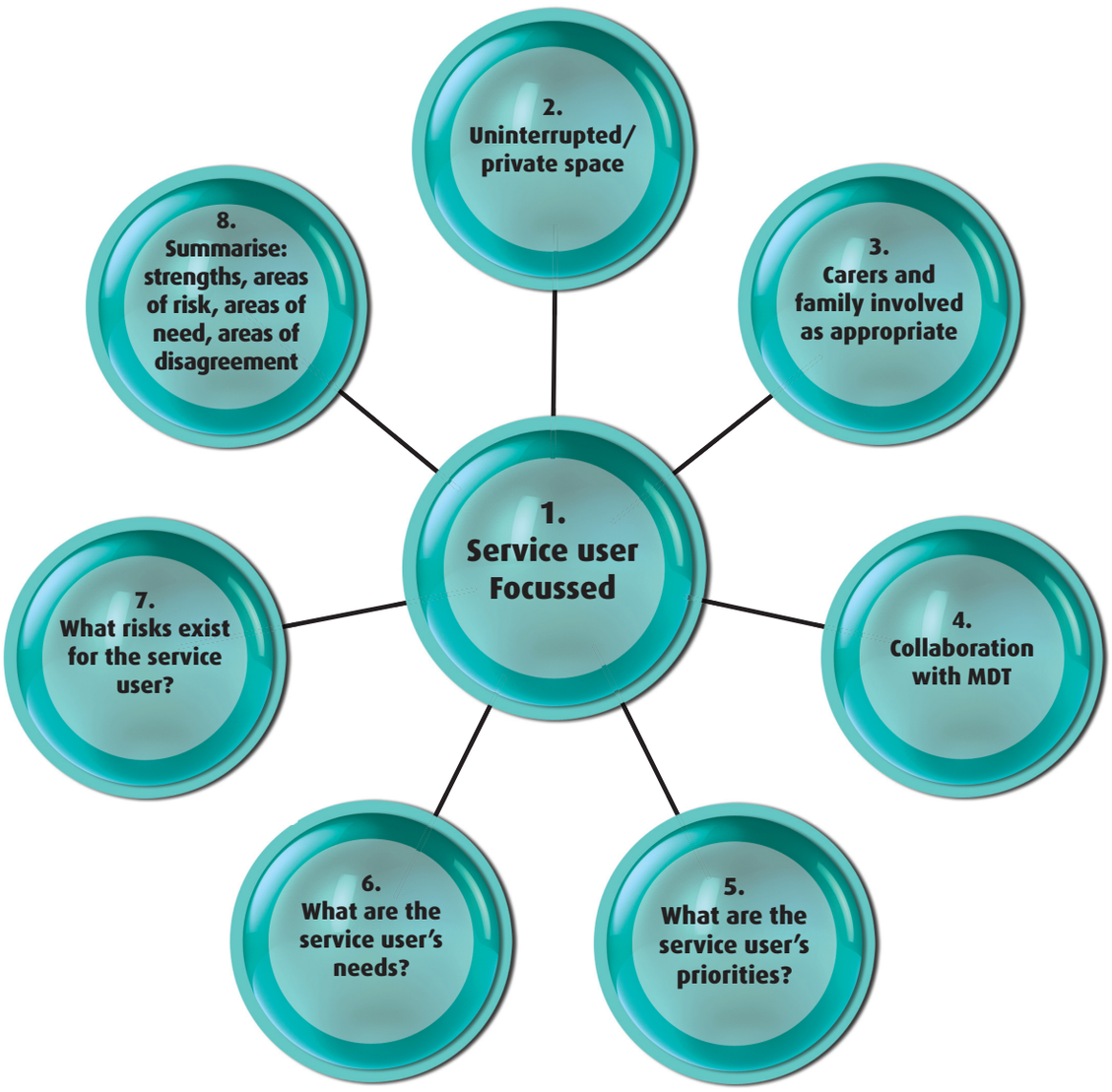
a. Assessment

In this document it is understood that a comprehensive assessment will be completed by the professional/s involved, in line with professional best practice. Key elements of the assessment process are illustrated in Diagram 2 below.

Furthermore, it is also understood that assessment is a collaborative process with other members of the multi-disciplinary team involved in supporting the service user in their journey to recovery and is in keeping with the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009).

Finally it is understood that the resulting information gleaned from the assessment/s informs the development of the care plan (see Diagram 1).

Diagram 2: Key Elements in the Assessment Process



The remaining components of the care planning process will now be explored in greater detail.

b. Identified Needs and Goals

When the assessor has taken into account the service user's views, the views of the carer (when appropriate) and his/her own observations and structured clinical judgment, the service user's needs must then be defined.

In the document *"Teamwork within Mental Health Services in Ireland"* (2010), the Mental Health Commission states that:

" Working from the interim care plan, a care co-ordinator's first task is to formulate a comprehensive recovery care plan that includes a 'time frame, goals and aims' and strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and user satisfaction.' Such a plan needs to outline achievable short-, medium- and long-term goals across all relevant life domains, the content of which will evolve over time." (pg 28)

It is acknowledged that there would be a need to review the care plan goals regularly depending on the ongoing assessment of the person's needs.

The identification of needs and goals contains the following components.

1	Identify needs
2	Highlight differences in need identification between professional and service user
3	Include needs re: risk, self care, quality of life issues and carer needs
4	Define recovery and treatment goals
5	Prioritise needs
6	Agree objectives for each prioritised need
7	Assign responsibility
8	Assign review date
9	Identify unmet needs
10	Sign Care Plan

This aspect of the care planning process should also be shared with the service user. It is not unusual for there to be a difference between what the service user or carer perceives to be a need and what the professional involved in the assessment perceives to be a priority. These differences should be acknowledged and recorded. The needs identified must include consideration of risk, support with self-care, needs of carers (as appropriate) and any other quality of life issues.

From this, priorities should be set in terms of service focus and provision. These priorities will include immediate needs and *recovery and treatment goals*. It is also important to identify the needs the service user considers a priority and the needs s/he is most motivated to address. This will help to illustrate what hopes and aspirations are important to the service user.

In produced by Cambridgeshire and Peterborough (2011), a very clear description of what a goal is, is provided.

"Goals are considered to be clearly defined, objective, specific, proactive if possible and time-bound. The importance of how goals are phrased is also highlighted, as it is felt that goals that are positive in nature are an integral part of recovery planning. Each goal written in the care plan should be a statement that indicates the desired outcome."

In the aforementioned document it is stated that:

- Recovery goals reflect the individual's hopes, choices and aspirations
- They are influenced by personality and values
- They are unique to that person, and generally they are forward-looking
- They are based on what the person actively wants to achieve in his or her life, rather than what the person wants to avoid
- Recovery goals are strengths-based and oriented towards reinforcing a positive identity and developing valued social roles.

It is usual for ***treatment goals*** to relate to the means by which the service user will be aided to make progress, to lessen the influence of an illness and preclude relapse, hospitalisation, and risk. Whereas ***recovery goals*** should contain actions and responsibilities for the service user, treatment goals largely concern activities undertaken by staff, working with the service user and his or her family. This forms the foundation of successful and prudent clinical care. (Cambridgeshire and Peterborough, 2011)

When needs and goals have been identified consideration should be given to the following points:

- Target interventions as precisely as possible on the identified needs
- Measurable and timed objectives, as far as possible
- Identification by name of the person responsible for the fulfilment of the objectives
- A date for the first review of the care plan.

A final important aspect of this stage is to identify needs that are not met by this care plan and detail why these specific needs are not being met. If there are unmet needs due to restrictions in terms of resources, multi-disciplinary team members availability, waiting lists etc. it is important that this information is fed back to the multi-disciplinary team and reported through the management structure.

Once the care plan is finalised the key-worker[2] and service user should sign the document. If the service user chooses not to sign the document, a record of this should be kept. The multidisciplinary team and service user are now committed to this document and to fulfilling the actions outlined in the plan. Once need and goal identification are complete, implementation of the document becomes the priority.

c. Implementation of the Care Plan

The following steps should be adhered to when implementing the care plan:

- Ideally, the key-worker should be responsible for overseeing the implementation of the plan
- Service users should be actively involved in implementation of their own care plan (an advocate may be required to facilitate this involvement)
- All those involved with the service user providing care and support should do so in a connected, co-ordinated fashion
- Implementation should begin in a timely manner, in the context of negotiations and agreement with the service user
- The implementation of the care plan should not weaken the service user's ownership of the plan.

The guiding principle of implementation should be to achieve the actions specified in the care plan with the minimum intervention necessary.

[2] The key-worker is acting on behalf of the team in signing the care plan. This does not abdicate responsibility of other team members in relation to the care plan.

d. Monitoring of the Care Plan

This role is ideally taken up by the key-worker as s/he can monitor the objectives of the plan and monitor the input of those responsible for the actions defined in the plan, in association with the service user. There are certain questions to be asked by the key-worker undertaking the monitoring role. These include:

- Are those responsible for actions, as identified in the plan, fulfilling their responsibility?
- Does the document continue to be valid in terms of reflecting the service users' needs and wishes?
- What changes need to take place to ensure the document remains current and relevant?
- Is an earlier review date required?

The aim of monitoring is to facilitate the achievement of the actions set out in the care plan.

Monitoring can contribute to refining the care plan and thereby keep the document dynamic and current. Any fine tuning of the care plan can take place with any changes made as a result, being recorded and reconsidered at the next review. Monitoring should record the progress made with regard to the defined actions. It also serves another very important function as it provides the basis of accountability. It should provide an early warning mechanism with regard to difficulties that may require an earlier review date, particularly in the context of risk or where a service user's situation deteriorates. Monitoring feeds directly into the review process.

e. Review Process

The review process should involve the service user, the key-worker and the multi-disciplinary team. A review fulfils a number of different purposes, namely:

- Review of whether care plan actions/goals have been achieved
- Examination of the reasons for progress and any barriers to progress
- Evaluation of the quality of the care provided
- Reassessment of current needs
- Revision of the care plan actions/goals
- Setting the date for the next review
- Recording the outcome of the review.

The service user choice of review participants should be facilitated when the review is being planned. The care plan should be revised in the light of the changes that have been made in the course of implementation and monitoring. The reason for any changes should be recorded, for example, lack of appropriate resources or changed preferences.

This revision should be done on the basis of agreement, and where this is not possible, any differences of view should be recorded. All contributors to a care plan should be notified of any significant revisions. Where the implementation and monitoring process has identified deficiencies, these should be notified to the relevant quarters, for example, service planning, inspection or quality assurance.

The review process should be needs-based. The review meeting should not solely focus on past needs, new or changed needs will require renewed assessment. The original goals and actions should be re-evaluated in the light of progress made. New goals should build on achievements made, with full participation of the service user and carer, as appropriate, and as before taking into account his/her views and priorities.

As before, any identification of unmet need should be highlighted and communicated to the multi-disciplinary team and through the management structure. Copies of the review report/revised care plan, in an accessible format, should be offered to the service user. A new review date should be set, with the contingency that an earlier review can be held if circumstances require it.

The final essential aspect of this process is discharge planning and although this comes at the end of the list of care planning components it is an aspect that begins from the moment of entry to the service.

f. Discharge Planning

Discharge planning is a structured and standardised process for ensuring the safe and successful transition of people with a mental illness between inpatient settings and from hospital to the community. It is part of the continuum of care that commences at the time of admission. The *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009) refers to a discharge plan as:-

> *"An information exchange tool and management plan focused on the discharge of a service user and his/her needs post-discharge including the management of risk. The discharge plan is a component of the individual care and treatment plan that defines expectations, roles and responsibilities".* (pg10).

Discharge planning principles are as follows:

- Admission and discharge are part of a continuum
- Service users and carers are partners in care
- Discharge criteria are based on comprehensive assessment of the service user's medical and psycho/social needs
- Effective discharge practice incorporates monitoring and evaluation
- Clear and timely communication between the service user, carer and all clinicians is essential
- A comprehensive discharge care plan should be developed before discharge, including links made with other agencies as relevant to the identified needs
- Provision of service user, and carer as appropriate, information and education is essential prior to discharge
- Standardised and monitored discharge processes support continuous system-wide improvement

To fulfil effective discharge planning the key-worker's role includes the need to oversee that each step of the discharge planning process is completed. In accordance with the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (2009) the key-worker should:

"liaise with the service user, family, carer and/or chosen advocate where appropriate and work with other members of the multi-disciplinary team to ensure that liaison with the general practitioner/primary care team and/or community mental health services and relevant outside agencies take place". (pg 39)

The date of discharge should be estimated and the likely service user needs identified, including any risks that may be expected. A discharge plan should be developed with the service user and others as relevant. Regular reviews of the plan should be carried out and all involved kept informed. Contemporary record keeping must form part of the discharge plan implementation and review. The discharge process itself must be monitored and evaluated with formal follow-up post discharge built into the plan.

Summary

As a means of refresher, listed below are the Individual Care Plan Components, that if fulfilled ensure compliance with Article 15 of the Mental Health Act, 2001:

- A documented set of goals
- Regular review and update of the plan by the service user's multidisciplinary team
- Consultation with each service user in so far as is practicable
- Specification of treatment and care required in accordance with best practice
- Identification of the necessary resources
- Specification of appropriate goals
- Records being kept in one composite set of documentation
- Consideration of education requirements in the case of a child

Inspector of Mental Health Services, 2011

Furthermore, ten reasons to implement care planning, as suggested by the Inspector of Mental Health Services are:

1. Respect for the patient
2. Good practice
3. Better patient co-operation
4. Good communication with the family, helping to involve them in the patient's care
5. Enhancing communication between the multi-disciplinary team and different shifts
6. Medico-legal defence
7. Improves measurement of progress towards all goals
8. Clearer identification and analysis of problems
9. Easier to audit care and treatment provided
10. It is legally required to do so.

The following care plan templates are for demonstration/educational purposes only. There is no requirement for these specific templates to be used.

Appendix I[3]

Sample Individual Care Plan Template (For use in hospital)

Name:	Phone No:
Address:	MRN No:
Date of Admission:	Date of Birth:

Consultant: _____ **G.P**_____

Key-worker: _____

Contact Person (next of kin)

Name: _____

Address: _____

_____

Relationship: _____

Contact details: _____

Do you give us permission to contact this person? Yes ☐ No ☐

Discharge

Estimated Discharge Date: _____

Other agencies to be involved (specify agency and named worker): _____

_____

_____

Arrange pre-discharge meeting (set date) No / Yes ___/_____ /_____

Carer /Family support to facilitate discharge: _____

GP Contact Details: _____

[3]This template is for demonstration/educational purposes only. There is no requirement for this specific template to be used in services.

Needs Identified[4] Desired Goals

No.		No.	

Action		Person Responsible	Date to be completed by:
No.			

Service User offered copy of care plan. Yes ☐ No ☐

Accepted by Service User (please tick) Yes ☐ No ☐

I have been involved in the development of this care plan:

Service User Signature: _____

Service user refused to sign care plan Yes ☐ No ☐

Key-worker signature: _____

[4]Following on from the needs identified in the assessment and service user input

Progress Notes on Implementation of Identified Care Plan Actions:

Action no.	Date	Comments	Signature

Care Plan Review:

(Include details on date, those present, actions evaluated and amendments made to Care Plan)

Service User offered copy of amended care plan. Yes ☐ No ☐

Accepted by Service User (please tick) Yes ☐ No ☐

I have been involved in the review of this care plan:

Service User Signature: _____

Service user refused to sign care plan Yes ☐ No ☐

Key-worker signature: _____

Discharge Plan:

Service User Name:	Admission date:
GP Name:	
Consultant:	
Reason for Admission:	Estimated date of Discharge:
Service User prefers to be discharged to:	

Discharge to:

Home ☐ Hostel ☐ Other _____

Accompanied by: Family ☐ Friend ☐ Advocate _____

Referrals to:

☐ Community Mental Health Nurse
☐ Home Care Team
☐ Day Hospital
☐ Day Centre
☐ Social Worker
☐ Occupational Therapist
☐ Psychologist
☐ Other (specify) _____

Relapse Prevention Plan:

(Include warning signs/triggers for relapse; social/family support in event of crisis and any agreed response arrangements, including out of hours services)

_____

_____

Recovery Plan:

(Include long term goals and timeframe as identified by service user)

_____

_____

Date of planned follow-up: _____

Staff responsible for follow up: _____

Name of staff and contact details given to service user: _____

Tel: _____

Email: _____

Service user's signature: _____

Key worker's signature: _____

Copy of Discharge plan given to Service User: Yes ☐ No ☐

Service user refused to sign care plan Yes ☐ No ☐

Discharge Summary[5]

Service User Details:
Name:
Address:
Phone Number:
Mobile phone number:
DOB: / / (dd/mm/yyyy)
Gender: Male ☐ Female ☐
Nationality:
PPSN:
Medical Card Number:
Consultant Psychiatrist Contact Information:
Name:
Address:
Contact Number:
Admission Details:
Date of Admission:
Type of Admission: Planned ☐ Unplanned ☐ Emergency ☐
Approved Centre Name:
Unit Name: Admission Unit
Discharge to:
Home ☐ Hostel ☐ Other ☐
Referred to:
Community MH Nurse ☐ Home Care Team ☐ Day Hospital ☐ Day Centre ☐ Social Services ☐
Psychologist ☐ Social Worker ☐ Occupational Therapist ☐
Other (specify)

Alerts/Current Risk

- ☐ Suicide – history
- ☐ Self Harm
- ☐ Harm to others
- ☐ Elder Abuse
- ☐ Substance Abuse
- ☐ Absconding/ wandering
- ☐ Fire risk
- ☐ Falls risk
- ☐ Drug reaction/allergy
- ☐ Accommodation
- ☐ Child protection
- ☐ Domestic safety issues

Vulnerability

- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Exploitation

Staff Alerts

- ☐ Animals on premises
- ☐ Poor lighting
- ☐ Location issues
- ☐ Unwanted visit
- ☐ Weapons

Other

_____

[5]This template is based on the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2009

Discharge Details:
Date of Discharge:
Approved Centre Name:
Unit Name:

Presenting Complaint:
Diagnosis:
Medications:
Known allergic reaction:
Mental State at discharge:
Individual care and treatment plan/discharge plan: Yes ☐ No ☐ Attached ☐
Management advice/follow up arrangements:
Prognosis:
Information given to the service user & relatives: Yes ☐ No ☐
Has the service user consented to the giving of information to his/her relatives? Yes ☐ No ☐

Key-worker Details:	**Other Key People for Follow Up::**
Name:	Name:
Job Title:	Job Title:
Phone Number:	Phone Number:

Additional Details:
Housing needs:
Social needs:
Voluntary agency:
Other support:
Risk Issues:
Relapse Prevention Strategy: Yes ☐ No ☐ Attached ☐
Crisis Management Strategy: Yes ☐ No ☐ Attached ☐

Signed:	Print name:
Job Title:	Date:
Service user signature:	Date:

Service user refused to sign: Yes ☐ No ☐

Appendix 2[6]

Completed Sample Individual Care Plan Template (For use in hospital)

Name: Joe Smith Address: Main Street, Anytown. Date of Admission: 18/11/2011	Phone No: 0841111222 MRN No: BN123 Date of Birth:17/04/1972

Consultant: Dr. B. Walsh
G.P: Dr. C. McCarthy
Key-worker: John Black

Contact Person (next of kin)
Name: Anne Smith Address: Main Street, Any town Relationship: Wife Contact details: 01-55555555 Do you give us permission to contact this person? Yes ☑ No

Discharge
Estimated Discharge Date: 9/12/2011 Other agencies to be involved (specify agency and named worker): GP (Dr. C. McCarthy), Day Hospital (CNM2 C. Murphy) Arrange pre-discharge meeting (set date) No / Yes 1/12 /2011 Carer /Family support to facilitate discharge: Yes, Anne Smith (wife) GP Contact Details: Dr. C. McCarthy 01-77777777

[6] ALL NAMES, CONTACTS, NUMBERS, ETC USED IN THIS COMPLETED SAMPLE INDIVIDUAL CARE PLAN TEMPLATE ARE FICTITIOUS

This template is based on the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2009

Needs Identified[7]		Desired Goals	
1.	Joe is re-experiencing low mood.	1.	Joe to manage his low mood and develop further skills in mood management.
2.	Joe is re-experiencing feelings of anxiety.	2.	Joe to manage his anxiety and practice skills in breaking the cycle of anxiety.
3.	Indicators for self harm are present.	3.	Joe's safety to be maintained and his reasons to live strengthened.
4.	Joe prefers to stay at home and sleep during the day.	4.	Joe to have increased desire to go out during the day and meet up with friends/ family and explore opportunities for work; have a better night's sleep.
5.	Joe's desire for/interest in food and fluid has reduced.	5.	Joe to enjoy a balanced diet.
6.	When Joe's feelings of anxiety and sadness improve there is a need to look at recovery supports and resilience building.	6.	Joe to have enhanced problem solving skills with identified wellness tools.
7.	Joe's wife, Anne, needs support to explore her understanding of Joe's experiences and how she could assist Joe to reduce stress and develop coping strategies.	7.	Anne to have resources with which she can support Joe and contribute to the strengthening of his and her resilience.
8.	Unemployment places financial strain on Joe and his family. A review of Joe's financial situation and his entitlements is needed with a view to developing a management plan for the family.	8.	The family to have a financial plan to work from.

[7]Following on from the needs identified in the assessment and service user input

Actions To Achieve Desired Goals:

No	Action	Person Responsible[8]	Date to be completed by:
1	Reinforce Joe's previous ability to cope and take control of his mood and anxiety, helping Joe to explore the reality of setbacks as a part of life. Work with Joe on graded exercise, accompanying him on walks regularly. Encourage Joe to take prescribed medication and view the prescription as one tool for recovery. Monitor for effects and side effects of the medication. Provide Joe with information on the risk and benefits of the prescribed medication, answering any questions he may have and encourage Joe to take an active role in his medication management as his mood improves.	Joe, Key-worker, Nurse, Psychiatrist, OT, Psychologist and designated other at times of Key-worker absence.	Daily
2	Help Joe to avoid a sense of demoralization with regard to a re-experiencing of anxiety and low mood. Emphasise his identification as a survivor and not a victim, and work with Joe to understand the time that is needed to achieve sustained change. Encourage Joe to take an active role in problem solving around the re-emergence of his anxiety issues, by recognizing that he is a resource in terms of important insights into his situation. Use CBT interventions in terms of coping self-statements and thought stopping. Provide Joe with relaxation exercises to practice.	Joe, Key-worker, Nurse, Psychologist and OT and designated other at times of Key-worker absence	Daily

[8]Those identified as responsible for the actions in this sample care plan are for illustrative purposes only. It is acknowledged that MDT's may not have the full complement of professionals available to the service user and will be limited to using the available resources.

No	Action	Person Responsible[9]	Date to be completed by:
3	Continually assess Joe's potential for self-harm and ask Joe to contribute to this assessment. Evaluate the level of precautions to be taken at least daily. Initially provide Level 2 supervision and accompany off the ward. Remove overt risks from Joe's environment. Support Joe in writing his own safety plan. Efforts should be ongoing and supportive and focused on strengthening Joe's desire to live. Elicit from Joe positive reasons and motivations to live.	Joe, Key-worker, Nurse and OT and designated other at times of Key-worker absence	Daily
4a	Explore with Joe the benefits and drawbacks of staying at home. Explore Joe's motivation to change and begin to support Joe to consider how staying at home negatively impacts on his wish to get back to work, identifying with Joe steps that he could take to overcome this challenge. Accompany Joe on activities, and as his mood/anxiety improves, expand the activities engaged in to the wider community.	Joe, Key-worker, Nurse, Psychologist and OT and designated other at times of Key-worker absence	9/12/2011
4b	Explore the reasons why Joe is sleeping during the day including what Joe perceives to be the benefits and drawbacks of this pattern. Joe would like to get back to work and sleeping during the day is not conducive to this goal; time spent working with Joe on highlighting this is important as a means of motivating Joe to endeavour to change this pattern. Encourage Joe to take regular, gentle, graded exercise and to avoid stimulants at bedtime. Provide support to Joe to undertake a sleep hygiene programme.	Joe, Key-worker, Nurse, OT and designated other at times of Key-worker absence.	Daily

[9]Those identified as responsible for the actions in this sample care plan are for illustrative purposes only. It is acknowledged that MDT's may not have the full complement of professionals available to the service user and will be limited to using the available resources.

No	Action	Person Responsible[10]	Date to be completed by:
5.	Explore with Joe the impact of poor nutritional intake on his health and wellbeing. Encourage Joe to take an active role in problem solving around his current lack of interest in food and support Joe in terms of his self-efficacy in the choices he makes with regard to his nutritional intake. As far as possible provide Joe with food and fluid that he chooses to eat/drink and as his mood and anxiety improve offer the option of Joe engaging in his own food preparation. Offer the Solution for Wellness programme to Joe as a means of providing Joe with understanding and tools to address his current struggle with maintaining a healthy diet.	Joe, Key-worker, Nurse, OT, Social Worker, Dietitian and designated other at times of Key-worker absence.	Daily
6.	Offer Joe support with WRAP as a means of strengthening Joe's resources and resilience. Support Joe in identifying his unique wellness tools.	Joe, Anne, Key-worker, Nurse, OT, Social Worker, Psychologist and designated other at times of Key-worker absence.	Ongoing
7.	Explore Joe's and Anne's understanding of the symptoms Joe experiences and ways of reducing, coping with or eliminating distress while also eliciting means by which Joe and his family can live a satisfying life. Provide psycho-education to Joe and Anne and explore Joe's motivation to engage with community supports such as AWARE.	Joe, Anne, Key-worker, Nurse, OT, Social Worker, Psychologist and designated other at times of Key-worker absence.	Ongoing
8.	Work with Joe and Anne on the family's financial situation and needs. Provide information to Joe & Anne on their entitlements and how to access supports. Devise a realistic, pragmatic plan in terms of finances with defined actions and targets. Refer to voluntary agency such as MABs.	Joe, Anne, Key-worker, Nurse, Social Worker and designated other at times of Key-worker absence.	9/12/2011

[10] Those identified as responsible for the actions in this sample care plan are for illustrative purposes only. It is acknowledged that MDT's may not have the full complement of professionals available to the service user and will be limited to using the available resources.

Template continued from page 35

(please tick)

Service User offered copy of care plan.	Yes ☑	No ☐
Accepted by Service User	Yes ☑	No ☐
I have been involved in the development of this care plan:	Yes ☑	No ☐
Service user refused to sign care plan	Yes ☐	No ☑

Service User Signature Joe Smith

Key worker signature: John Black

Progress Notes on Implementation of Identified Care Plan Actions:

Action no.	Date	Comments	Signature

Care Plan Review:

(Include details on date, those present, actions evaluated and amendments made to Care Plan)

Service User offered copy of amended care plan. Yes ☐ No ☐

Accepted by Service User (please tick) Yes ☐ No ☐

I have been involved in the review of this care plan:

Service User Signature:_____

Service user refused to sign care plan Yes ☐ No ☐

Key worker signature:_____

Discharge Plan:

Service User Name: Joe Smith	Admission date:
GP Name: Dr. C. McCarthy	
Consultant: Dr. B. Walsh	
Reason for Admission: Depressed mood, anxiety and inability to cope	Estimated date of Discharge: 9/12/2011
Service User prefers to be discharged to: Home	

Discharge to:

Home ☑ Hostel ☐ Other _____

Accompanied by: Family ☑ Friend ☐ Advocate _____

Referrals to:

☑ Community Mental Health Nurse
☐ Home Care Team
☐ Day Hospital
☐ Day Centre
☑ Social Worker
☑ Occupational Therapist
☐ Psychologist
☑ Other (specify) MABS

Relapse Prevention Plan:

(Include warning signs/triggers for relapse; social/family support in event of crisis and any agreed response arrangements, including out of hours services, as identified by service user)

- I start to feel tired and then I stay in bed instead of getting up. Then I don't sleep well at night and I feel sad and alone, especially at night.
- I should try to get more exercise during the day so that I can maybe sleep better at night. Even if I don't want to exercise I know I feel better afterwards.
- If I feel overwhelmed I think I can't cope and I try to avoid situations that make me feel this way. When this happens I should ask for help early on and keep going with the situation but maybe with more support.
- My support is my wife but sometimes I think she doesn't know what to say or do and I can be sharp with her telling her she doesn't understand. I would like support outside of my immediate family maybe my Key-worker or GP.
- I will ring my Key-worker if I begin to feel overwhelmed and I will start to use the relaxation exercises regularly.
- I will try a support group in town, to see if it is a help.

Recovery Plan:

(Include long term goals and timeframe as identified by service user)

To get on with living. To have a job and to be able to do things with my wife and kids. I want to enjoy Christmas with my family and I want to get work by next spring. This is what I want to happen so I have to work towards it. I will try to achieve these things by:

- Getting out of the house for at least half an hour every day
- Minding myself a bit more – if I start having difficulties sleeping I will speak to Anne about it and also practice the relaxation exercises I learnt in hospital
- I'm going to make an appointment to see a person in Solas about what I need to do to try to get some work
- I'm going to ask for help with my CV and also with some practice interviews, I don't feel very confident about doing interviews so I need help with this
- I want to make a list of all the things I can do that help me recover, as I have recovered before and hope I can again. I need help from my community nurse with this. I will arrange to see her at least once a month.
- I will go to AWARE meetings at least once a month as it gets me out and also helps with how I feel about myself.

Goals are me feeling well again, having energy to do things, being able to look for work. If I get better I will try to stay going and not let things slide again. I shouldn't give in when I feel like this and I should try not to slip into doing nothing. I will use my wellness tools which are:

- Getting out with my family for walks
- Soaking in a bath
- Exercising for a half hour
- Eating good food and eating regularly
- Meeting up with Pat for a game of snooker
- Remembering I've recovered before and can do it again.

I will review this with Anne, AWARE and my community nurse to help keep me on track.

Date of planned follow-up: 19/12/2011 Staff responsible for follow up: Mary McDonagh CMHN

Name of staff and contact details given to service user:
Mary McDonagh CMHN Tel: 01-4444444 Email: mmcdonagh@waterloocare.ie

Service user's signature: Joe Smith Key worker's signature: John Black

Service user refused to sign care plan Yes ☐ No ☑
Copy of Discharge plan given to Service User: Yes ☑ No ☐

Discharge Summary[11]

Service User Details:
Name: Joe Smith
Address: Main Street, Anytown
Phone Number: 0841111222
Mobile phone number: 08411112222
DOB: 17/04/1972
Gender: Male ☐ Female ☑
Nationality: Irish
PPSN: 123456789
Medical Card Number: 987654321
Consultant Psychiatrist Contact Information:
Name: Dr. B. Walsh
Address: Another Street, Anytown
Contact Number: 1111111111111
Admission Details:
Date of Admission:
Type of Admission: Planned ☑ Unplanned ☐ Emergency ☐
Approved Centre Name: St. Aidan's
Unit Name: Admission Unit
Discharge to:
Home ☑ Hostel ☐ Other ☐
Referred to:
Community MH Nurse ☑ Home Care Team ☐ Day Hospital ☐ Day Centre ☐ Social Services ☐
Psychologist ☐ Social Worker ☑ Occupational Therapist ☐
Other (specify) ☑ MABS

Alerts/Current Risk

- ☐ Suicide – history
- ☐ Self Harm
- ☐ Harm to others
- ☐ Elder Abuse
- ☐ Substance Abuse
- ☐ Absconding/ wandering
- ☐ Fire risk
- ☐ Falls risk
- ☐ Drug reaction/allergy
- ☐ Accommodation
- ☐ Child protection
- ☐ Domestic safety issues

Vulnerability

- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Exploitation

Staff Alerts

- ☐ Animals on premises
- ☐ Poor lighting
- ☐ Location issues
- ☐ Unwanted visit
- ☐ Weapons

Other

_____

[11]This template is based on the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, 2009

Discharge Details:
Date of Discharge: 09/12/2011
Approved Centre Name: St. Aidan's
Unit Name: Admission Unit

Presenting Complaint: Depression and anxiety
Diagnosis: Moderate Depression
Medications: Seroxat 40mgs mane
Known allergic reaction: None
Mental State at discharge: Mood is improved. Slight anxiety re: coping skills
Individual care and treatment plan/discharge plan: Yes ☑ No ☐ Attached ☑
Management advice/follow up arrangements: Key-worker available at times of crisis. C.M.H.N allocated and details given to Joe. Relapse prevention and discharge plans have been developed with Joe. Referrals made to MABS, Social Worker and Occupational Therapist.
Prognosis: Good with support
Information given to the service user & relatives: Yes ☑ No ☐
Has the service user consented to the giving of information to his/her relatives? Yes ☑ No ☐

Key-worker Details:	**Other Key People for Follow Up:**
Name: John Black	Name: Mary McDonagh
Job Title: RPN	Job Title: Community Health Nurse (C.M.H.N)
Phone Number: 33333333333333	Phone Number: 01 - 4444444

Additional Details:
Housing needs: Not applicable
Social needs: Will go to Solas regarding seeking employment
Voluntary agency: Not applicable
Other support: Will attend local self-help support group
Risk Issues: Not at discharge
Relapse Prevention Strategy: Yes ☑ No ☐ Attached ☑
Crisis Management Strategy: Yes ☑ No ☐ Attached ☐

Signed: John Black	Print name: JOHN BLACK
Job Title: RPN	Date: 09/12/2011
Service user signature: Joe Smith	Date: 09/12/2011

Service user refused to sign: Yes ☐ No ☑

Appendix 3[12]

Sample Individual Care Plan Template (For use in the community)

Name: Address: Date of Admission:	Phone No: MRN No: Date of Birth:

Consultant: _____ **G.P**_____

Key-worker: _____

Contact Person (next of kin)

Name: _____

Address: _____

_____

Relationship: _____

Contact details: _____

Do you give us permission to contact this person? Yes ☐ No ☐

Discharge

Estimated Discharge Date: _____

Other agencies to be involved (specify agency and named worker): _____

_____

_____

Arrange pre-discharge meeting (set date) No / Yes ___/_____ /_____

Carer /Family support to facilitate discharge: _____

GP Contact Details: _____

[12]This sample individual care plan template is for demonstration/educational purposes only. There is no requirement for this specific template to be used.

Needs Identified[13] Desired Goals

No.		No.	

Action		Person Responsible	Date to be completed by:
No.			

Service User offered copy of care plan. Yes ☐ No ☐

Accepted by Service User (please tick) Yes ☐ No ☐

I have been involved in the development of this care plan:

Service User Signature: _____

Service user refused to sign care plan Yes ☐ No ☐

Key-worker signature: _____

[13]Following on from the needs identified in the assessment and service user input

Progress Notes on Implementation of Identified Care Plan Actions:

Action no.	Date	Comments	Signature

Long Term Recovery Plan:

(Include long term goals and timeframe as identified by service user)

Care Plan Review:

(Include details on date, those present, actions evaluated and amendments made to Care Plan)

Service User offered copy of amended care plan. Yes ☐ No ☐

Accepted by Service User (please tick) Yes ☐ No ☐

I have been involved in the review of this care plan:

Service User Signature:_____

Discharge Plan:

Service User Name: _____

Date: _____

GP Name: _____

Consultant: _____

Summary of Discharge from Community Team:

Service User Signature:_____

Copy of Discharge plan given to Service User: Yes ☐ No ☐

Service user refused to sign care plan Yes ☐ No ☐

Key worker signature:_____

Appendix 4 - Audit Tool for Individual Care Planning (ICP)

Instructions

This audit tool has been designed to support mental health services to audit their processes and practices with regard to Individual Care Planning. The tool is broken into two parts; the first part looks at service processes and the second part looks at the standard of practice with regard to Individual Care Plans. It is recommended that service providers audit Individual Care Plans' as per Standard 8.3 of the *Quality Framework Mental Health Services in Ireland* (2007); specifically criteria 8.3.7 which states that: *"The mental health service implements a clinical governance system for improving clinical practice."* The frequency of audit should be dictated by best practice and be increased particularly where audit results indicate that the standard is below the acceptable best practice/ legislative requirements.

When completing part 2 of this audit, auditors should take a reasonably representative number of individual care plans. For example if there are 200 people availing of the service then 20 plans should give a reasonably representative view of the quality of Individual Care Plans. Similarly if there are 20 people availing of the service, 6-10 plans should suffice. Where the service has several sectors, then a representative sample should be taken from each sector as it is important that each sector / team is audited.

It is of fundamental importance that the results of any audit carried out are discussed within the Management Team and/or the Quality Committee of the mental health service. Any deficits with regard to meeting best practice / legislative requirements should be addressed in an action plan and further audit should take place within a reasonable timeframe to ensure that the action plan has been effectively implemented.

Name of Service_____

Date of Audit_____

Name of Auditor(s)_____

Part 1 - Audit of the Mental Health Service's Individual Care Planning Process

Audit Question	Method of Audit	Compliance	Auditors Comments
1.1 Does the mental health service have an individual care planning (ICP) framework in use?	*Documentation Check* • Check for presence of framework • Check that framework is being used in practice	Yes ☐ No ☐	
1.2 Does the mental health service have a policy in place with regard to ICP's that is in keeping with the Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (2009)?	*Documentation Check* • Check for presence of policy • Check for sign-off sheets illustrating that staff have read this policy	Yes ☐ No ☐	
1.3 Has the mental health service provided training to staff in relation to ICP's?	*Documentation Check* • Check training records for evidence of same	Yes ☐ No ☐	
1.4 Is the service user aware of their ICP?	*Interview* • Speak with a number of service users to establish same *Documentation Check* • Check whether the service has a service user information booklet and that this refers to ICP's	Yes ☐ No ☐	
1.5 Has the mental health service provided training to key-workers with regard to ICP's?	*Interview* • Speak with a number of staff to establish same *Documentation Check* • Check training records for evidence of same	Yes ☐ No ☐	

Audit Question	Method of Audit	Compliance	Auditors Comments
1.6 Does the mental health service audit ICP's in line with Standard 8.3 of the Quality Framework Mental Health Services in Ireland (2007)?	*Documentation Check* • Check for audit report/s completed in the last year	Yes ☐ No ☐	
1.7 Does the mental health service implement improvements to ICP's as a result of these audits?	*Documentation Check* • Check action plan from audit report and look for written evidence that the action plan has been implemented	Yes ☐ No ☐ N/A ☐	

Part 2 – Audit of Individual Care Plans

The audit questions in **bold green** reflect the legal requirements of Article 15 of the Mental Health Act (2001). The other questions reflect best practice.

Audit Question	Method	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	Totals
2.1 Are all records relating to the person maintained in one composite set of documentation?	*Check in area where records are maintained to determine same*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.2 Does the care plan demonstrate that the service user has been consulted with, in as far as practicable?[14]	*Check each ICP being audited. Check for signature of service user and check that service user has been involved in the process, as far as practicable*	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.3 Does the care plan demonstrate that the service user has been offered a copy of their plan?	*Check each ICP being audited.*	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.4 If the service user refused to have a copy of their plan, has their choice been documented?	*Check each ICP being audited.*	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	

[14] The only time N/A (Not Applicable) should be ticked is if the person's individual care plan clearly states that they could not be consulted due to their mental state at that time.

Audit Question	Method	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	Totals
2.5 Does the plan have a "strengths based" focus?	Check each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.6 Is the plan person-centred?	Check each ICP for person-centred language and focus	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.7 Where there is an assessed need is there a corresponding treatment or care plan in place to address that need?	Check each assessed need and see if there is a plan in place with regard to that need	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.8 Is the treatment or care identified in the care plan in accordance with best practice?	Check each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.9 Is there a documented set of goals?	Check each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.10 Are the goals appropriate?	Check that the goals identified are appropriate to assessed needs	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Audit Question	Method	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	Totals
2.11 Is there written evidence that the care plan has been implemented?	Check for evidence of same in each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.12 Is there written evidence that implementation of the plan is being monitored?	Check for evidence of same in each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.13 Are the necessary resources required, identified in the care plan?	Check each ICP being audited	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.14 Is there evidence of regular review of the care plan?	Check for written evidence of regular reviews	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.15 Is the care plan reviewed in accordance with review dates set in the care plan?	Check whether reviews occur in accordance with planned dates	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.16 Is there evidence that the care plan has been updated during each review?	Check for new revision of care plan after each review	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Audit Question	Method	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	Totals
2.17 Is there evidence that the review is based on a Multidisciplinary team approach?	Check for written evidence of team involvement Check for MDT involvement (if this is relevant to the service user's needs)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
2.18 Is there a discharge plan in place?[15]	Check each ICP being audited	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.19 Is there evidence that the service user has been involved in their discharge plan?	Check each ICP being audited – check for evidence of service user involvement	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.20 Has the service user been given a copy of their discharge plan?	Check for written evidence of same in the person's plan	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.21 Is there evidence that the discharge plan is being monitored?	Check for written evidence of same in the person's plan	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	
2.22 Where the care plan relates to a child, is there evidence that their education requirements have been considered during the planning process?	Check each ICP being audited	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	

[15] Not applicable can only apply if a service user is receiving care and treatment in a continuing care setting.

Auditors Additional Comments / Notes

Summary of Audit

Level of compliance	
Numbers of YES	
Numbers of NO	
Numbers of N/A	

Are all mandatory requirements being met in accordance with Section 15 of the Mental Health Act? YES ☐ NO ☐ N/A ☐

(If no, this should be addressed as soon as possible in the action plan)

Summary of Strengths Evident: _____

_____

_____

_____

_____

_____

Summary of Areas for Development: _____

_____

_____

_____

_____

_____

Auditor Name(s)_____

Auditor Signature(s) _____

Date of Audit:_____

Audit Improvement Action Plan – Individual Care Planning

Date:_____

Area:_____

Present (Names and Titles):_____

Improvement required as a result of the audit	Action(s) necessary for improvement	Person responsible for action	Deadline Date	Outcome/ Progress Report
1.				
2.				
3.				

Name of person responsible for overseeing implementation of this plan:

_____

Signature: _____

Date:_____

Appendix 5 – Reference

Cambridgeshire and Peterborough (2011) ***Care planning Guidance.*** NHS Foundation Trust, United Kingdom.

Department of Health & Children (2006) '***A Vision for Change' Report of the Expert Group on Mental Health Policy***. Stationary Office, Dublin.

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Shepherd G., Boardman J. & Slade M. (2008***) Making Recovery a Reality.*** Sainsbury Centre for Mental Health, London:

Slade, M. (2009), ***100 Ways to Support Recovery,*** Rethink, London.