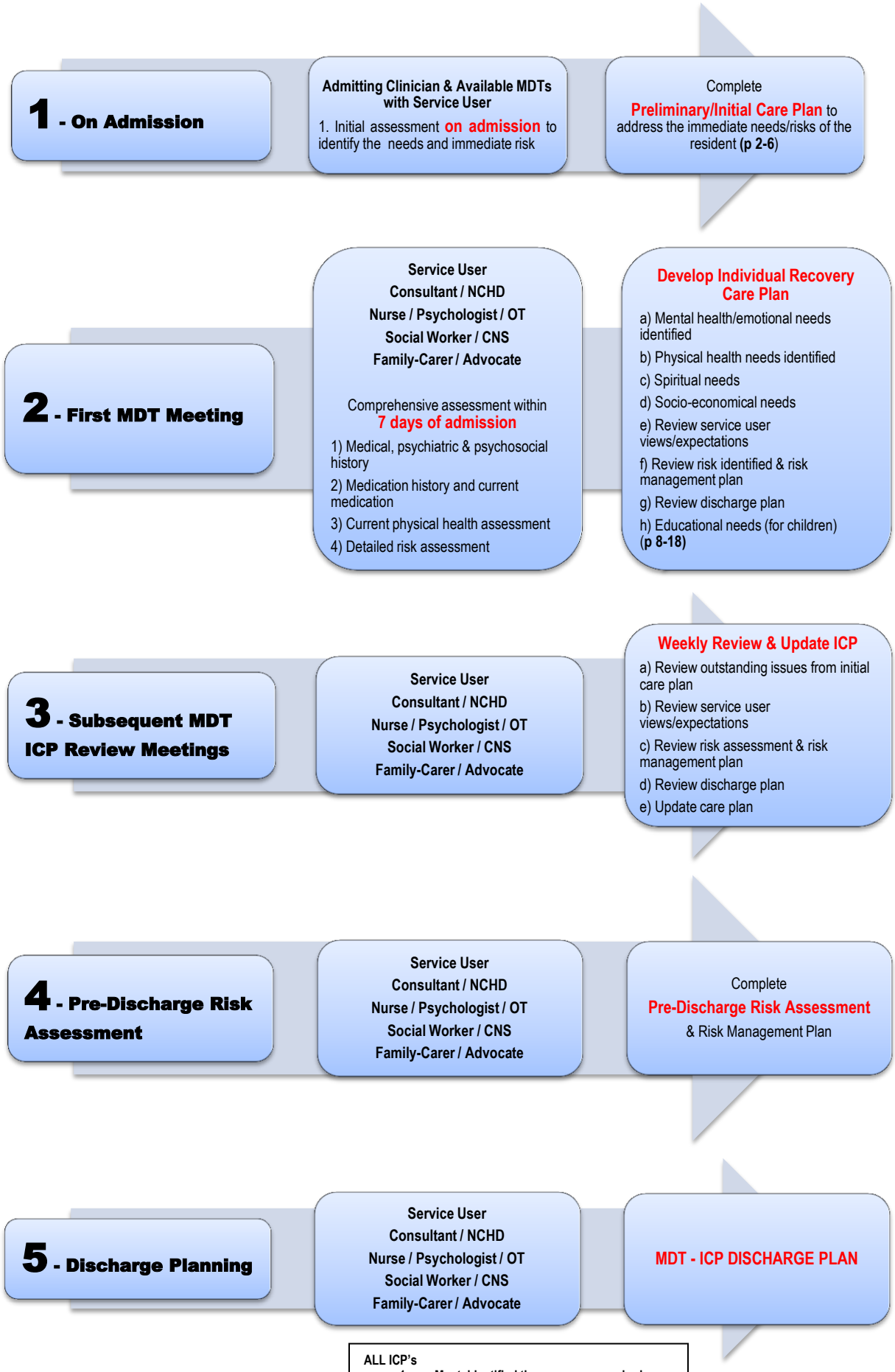
Community Healthcare East

INDIVIDUAL RECOVERY CARE PLAN

Please Affix Patient Label Here

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



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

For INDEX OF NEED, See Page No. 2 or 8

Health Service Executive

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:**	**CMHN:**
Social Worker:	**Psychologist:**	**Dietician**
Others:		

NEXT OF KIN

Name: _____ **Relationship:** _____

Address: _____

Contact No.: _____ **Permission to Contact:** Yes ☐ No ☐

GP DETAILS

Name: _____ **Contact No.:** _____

Address: _____

PHARMACY DETAILS

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:**

For INDEX OF NEED, See Page No. 2 or 8

PRELIMINARY
INDIVIDUAL RECOVERY CARE PLAN

To Be Completed
On admission By the Admitting Clinician

Please Affix
Patient Label Here

RISK ASSESSMENT

ADMISSION

Risk Area			
Risk of self-harm & risk of suicide: (Specify- suicidal ideation, plans or intent)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Risk of violence/challenging behaviour:(For example; abusive language, expressing violent thoughts, conformational or intimidating behaviour)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Personal vulnerability (For example; Exploitation, risk poor communication or social isolation)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Personal risk to staff:(For example: Special infection hazard, vexatious interaction, resistive or suspicious to staff)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Medical, Substance misuse, Environmental & any other risks:	Yes	No	N/A
Identified risk:			
Risk Management Plan:			

Name of Risk Assessor: _____ Signature: _____ Date _____

For INDEX OF NEED, See Page No. 2 or 8

Health Service Executive

"PRELIMINARY" INDIVIDUAL RECOVERY CARE PLAN

To be completed on admission by admitting clinician

Please Affix Patient Label Here

Unit: _____

Date: _____

Time: _____

Completed By: _____

Service User in Attendance: Yes ☐ No ☐ If No, why? _____

Initial Observation Required:

General (Hourly) ☐ Close Observation (30 minutes) ☐ Special (Constant) ☐

Rationale: _____

Initial Leave Status: _____

Rationale: _____

Day Clothes ☐ Night Clothes ☐

Rationale: _____

Visiting Restrictions: Yes ☐ No ☐

Rationale: _____

For INDEX OF NEED, See Page No. 2 or 8

No.	Needs Identified	Desired Goals	Action (Treatment & Care)	Resource/Responsible Person

ICP explained to Service User: Yes ☐ No ☐ If No, why? _____

Service User agrees with content of ICP? Yes ☐ No ☐

Copy of ICP offered to Service User: Yes ☐ No ☐ If No, why? _____

Signed (on behalf of MDT): _____ Date: _____

Service User Signature: _____ Date:

Next ICP Review Date

_____

For INDEX OF NEED, See Page No. 2 or 8

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**
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	

Please Affix
Patient Label Here

PRE-MDT REVIEW 1

Date:

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 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 ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

For INDEX OF NEED, See Page No. 2 or 8

Please Affix
Patient Label Here

PRE-MDT REVIEW 2

Date:

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 ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

Please Affix
Patient Label Here

PRE-MDT REVIEW 3

Date:

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 3

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? _____

For INDEX OF NEED, See Page No. 2 or 8

Please Affix
Patient Label Here

PRE-MDT REVIEW 4

Date:

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 4

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? _____

For INDEX OF NEED, See Page No. 2 or 8

Please Affix
Patient Label Here

PRE-MDT REVIEW 5

Date:

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 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 ☐ If No, why? _____

Has Service User Been Offered a copy of ICP? Yes ☐ No ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

Please Affix Patient Label Here

PRE-MDT REVIEW 6

Date:

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 ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

Please Affix Patient Label Here

PRE-MDT REVIEW 7

Date:

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? _____

Please Affix Patient Label Here

PRE-MDT REVIEW 8

Date:

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 ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

Please Affix Patient Label Here

PRE-MDT REVIEW 9

Date:

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 ☐ If No, why? _____

Has Service User Been Offered a copy of ICP? Yes ☐ No ☐ If No, why? _____

Service User Signature: _____ If No, why? _____

Please Affix Patient Label Here

PRE-MDT REVIEW 10

Date:

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 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 ☐ 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

Date	Weekly / Six monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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 monthly Needs Review & Progress Evaluation	MDT Signature

For INDEX OF NEED, See Page No. 2 or 8

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:			
Risk of violence/challenging behaviour:(For example; abusive language, expressing violent thoughts, conformational or intimidating behaviour)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Personal vulnerability (For example; Exploitation, risk poor communication or social isolation)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Professional risk:(For example: Special infection hazard, vexatious interaction, resistive or suspicious to staff)	Yes	No	N/A
Identified risk:			
Risk Management Plan:			
Medical, Substance misuse, Environmental & any other risks:	Yes	No	N/A
Identified risk:			
Risk Management Plan:			

Health Service Executive

RECOVERY CARE PLAN ON DISCHARGE

Health Service Executive
Community Healthcare East Mental Health Services

Please Affix Patient Label Here

Unit: _____

Date of Current Admission: _____

Last ICP Review: _____

Pre-Discharge Meeting Date: _____

ICD 10 Classification on Discharge: _____

DISCHARGE TO:

Home ☐ Hostel ☐ Sheltered Accommodation ☐

Other ☐ _____

Accompanied by:

Family ☐ Friend ☐ Advocate ☐

Other ☐ _____

Full Discharge Address: _____

Telephone No.: _____

REFERRALS TO:

Community Mental Health Nurse ☐ Social Worker ☐ Homecare Team ☐ OT ☐

Day Hospital ☐ OPD ☐ Day Centre ☐ Psychology ☐ GP ☐

Other ☐ _____

Multidisciplinary Team Names / Contact Numbers

Consultant:	**Contingency contact details:**
Community Mental Health Nurse/ Day Hospital Nurse:	
Psychologist:	
Registrar:	
OT:	
Social worker:	

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		

SUMMARY OF RECOVERY CARE PLAN *(Including early warning signs of relapse and crisis intervention plan)*

_____

_____

_____

_____

_____

_____

_____

Next Appointment Date: _____

Service User agrees with content of Recovery Care Plan? **Yes** ☐ **No** ☐ **If No, why?** _____

Copy of Recovery Care Plan offered to Service User: **Yes** ☐ **No** ☐ **If No, why?** _____

Communication to GP Regarding Discharge **Yes** ☐ **No** ☐ **If No, why?** _____

Signed (on behalf of MDT): _____ **Date:** _____

Service User Signature: _____ **Date:** _____

For INDEX OF NEED, See Page No. 2 or 8

Health Service Executive

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: _____ **Date:** _____