Writing a Person-centred Individual Care Plan **Guidance Document**

A guide to support HSE Mental Health Services staff with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15, Individual Care Plan

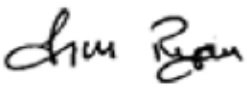
Contents

Foreword

It is my pleasure to introduce this guidance document on writing a person-centred individual care plan. Delivering safe, high-quality and recovery-focused care is the primary aim of HSE Mental Health Services.

The aim of the guidance document is to enable you to easily navigate the requirements of Regulation 15 and to provide samples to support you in your endeavours. In doing so, we will ensure regulatory compliance as a result of day-to-day practice.

The guidance document for the development of a person-centred individual care plan has been co-produced by the HSE Mental Health Operations team and a broad range of stakeholders. In particular, I would like to express my thanks to the service users' leads and service users who were part of the development process, generously giving their time and sharing their experiences. I would also like to thank the approved centre staff who engaged in recent training, and whose experiences and challenges shaped this document.



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Background

The Heath Service Executive (HSE) describes a care plan as a treatment plan co-produced by the service user and the service user's mental health team covering what will be done to address the service user's mental health difficulties. It identifies particular mental health challenges, issues or needs experienced by the service user and sets out a plan to address these challenges, issues or needs.

The care plan ensures that the service user gets the most appropriate care from their mental health team at the right time. The care plan should always include assessments of the service user's health, personal and social care needs, as well as the participation of the service user, in order to help their recovery process.

The care plan should be developed with specific goals and targets. It should address the service user's priority needs, including discharge planning and onward referral within a community setting. It should be written in jargon-free, recovery-focused language that can be easily understood.

Care planning can be viewed as a developing, progressive record of a person's care process, and, where possible, the document should be co-produced by the service user and the members of the multidisciplinary team (MDT) involved. It should show progression – whether an improvement or a deterioration in physical health or mental health – and will consider a range of issues for the person.

The purpose of this guidance document is to support good MDT practice in individual care planning and measure the service user's progress throughout our mental health services. It sets out the key elements of the care planning process and how these meet the criteria for compliance with Regulation 15, Individual Care Plan.

The document is divided into two parts, as follows:

Part 1: Contains step-by-step guidance on the actions required in order for care planning to be compliant with Regulation 15, Individual Care Plan.

Part 2: Contains practical examples of how to write a person-centred individual care plan (ICP) that is compliant with Regulation 15, Individual Care Plan. Assessments and examples are for illustrative purposes only.

The Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15, defines an ICP as follows:

"'Individual care plan' means 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."

The Mental Health Commission (MHC) regulates approved centres (inpatient mental health services). Its monitoring of mental health services and the registration and inspection of approved centres is in line with the legal requirements of the Mental Health Act, 2001.

Recovery

Recovery is a process of change through which people with lived experience of a mental health challenge improve their overall health and wellness, live a self-directed life, and strive to reach their full potential. The recovery approach moves beyond the concept of a cure towards the beginning of a journey with peaks and sometimes troughs, victories and challenges, big and small. In the literature, new understandings of recovery are being established that emphasise the primacy of personal decision-making supported by clinical best practice and lived mental health experience. Recovery is holistic, embracing all areas of a person's life, and is sustained through clinical supports and services alongside a range of community and other supports such as housing, employment and social integration (National Framework for Recovery in Mental Health HSE, 2018).

Recovery is personal and unique to each individual, in accordance with their goals and aspirations, and is non-linear; it looks different for everyone. It focuses on the whole person, not just their mental health. As such, it challenges the individual to move towards a meaningful and satisfying life with or without the presence of a mental health challenge. Above all, the recovery approach recognises the individual's values and beliefs, hopes and dreams, strengths and qualities, and instils a sense of hope, emphasising self-determination.

Introduction

Following the full implementation of the Mental Health Act, 2001 in 2006, the Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006) were drafted. Regulation 15 mandates the registered proprietor of each approved centre to ensure that each resident has an ICP. The MHC considers care planning and the ICP document to be essential to person-centred, recovery-based care within inpatient and community residential settings.

The ICP is one of the central documents that demonstrates and evidences whether or not a service user has an active role in decisions about their care and whether there are multidisciplinary inputs and resources available for their treatment, together with a collaborative road map for each service user's recovery.

Two other regulations are linked directly with Regulation 15, Individual Care Plan:

- Regulation 16(1) mandates that "each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan".
- Regulation 7(2) mandates that "night clothes are not worn by residents during the day, unless specified in a resident's individual care plan".

In 2015, the MHC introduced the *Judgement Support Framework* (JSF Version 5.1, 2020), which provides detailed assistance for approved centres on best practice in care planning, including standards around processes, training and monitoring for care planning. This sets the criteria that the Inspector of Mental Health Services expects to be evident when inspecting each ICP. The *Judgement Support Framework* is a guidance document to assist services in achieving compliance with the regulations and in achieving a standard beyond the minimum level of compliance set by way of regulation. This is the benchmark for care planning in terms of compliance. However, the Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006) the statutory framework against which care planning is assessed.

In 2017, the *HSE Best Practice Guidance for Mental Health Services* Theme 2, Aim 2, Indicator 2.1 of the *Best Practice Guidance* states that: "Each service user has an individual care and treatment plan (ICP[1]) that describes the levels of support and treatment required in accordance with his/her needs and is co-ordinated by an identified team." See appendix 2.

1 Individual Care Plan

Regulations 3, 5, 7, 8, 11, 15, 16, 17, 19 and 31 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No. 551 of 2006.

Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services (April 2012)

Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre.

Mental Health Commission Quality Framework Standard 1.1.

Multidisciplinary team working

Many individuals will have a role in the co-production of care plans. This must encompass the involvement of the service user as well as other important stakeholders such as their family/carer/advocate (where applicable and with the consent of the service user), a key worker, a consultant psychiatrist, a mental health nurse, a psychologist, an occupational therapist, a social worker, and possibly others, such as a dietician or art therapist. The compilation of this list will be dependent on what type of MDT the service can provide.

Key worker

The key worker role is identified in the *Quality Framework* (2007) in Standard 1:1, as follows:

"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 key worker can be any grade of staff member.

The assignment of the key worker should be based on consideration of the priority needs of the service user and the member of the MDT who can most appropriately support the service user to attain their goals. Therefore, if housing, for example, is a priority need for the person, then a social worker is the most appropriate person to be the key worker.

Consideration should also be given to changing the key worker if the person's needs change or if they are not comfortable working with the assigned key worker.

Part 1

Criteria for compliance with Regulation 15

Part 1
Criteria for compliance with Regulation 15

Table 1 – Criteria for compliance with Regulation 15 (Individual Care Planning 2016-2018 in Review. Mental Health Commission. January 2020).

Regulation 15 requires that each approved centre resident has an ICP. The definition set out in the regulation adds a number of specific criteria to that requirement, as follows:

1. **ICP in place (interim)**
2. **Full MDT ICP in place within 7 days**
3. **Service user involvement**
4. **MDT input developed and reviewed**
5. **Appropriate goals for the resident, not the treating team**
6. **Care and treatment to meet goals**
7. **Resources to provide care and treatment**
8. **Reviewed within a specified time frame – 7 days for an acute episode, and every 6 months for continuing care**
9. **Composite set of documentation**
10. **Education requirements (children only)**

Regulation 15 means that not only must every approved centre resident have an ICP in place but each ICP must be assessed against nine separate elements (10 elements for children). During the course of an inspection, a sample of 10 ICPs is reviewed. It is important to note that failure to meet just *one* of the nine requirements (10 requirements in Child and Adolescent Mental Health Services (CAMHS) in *one* care plan will result in a rating of non-compliance on inspection. In 2012, and again in 2020, the MHC published two documents to identify the components required for the ICP.

If each of the criteria in Table 1 is fulfilled for each care plan and for each service user, then the mental health service provider will be fully compliant with Regulation 15 of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

Criterion 1
ICP in place (interim)

The steps required in order to meet Criterion 1 (ICP in place) include assessment, the admission process, and discharge planning.

Assessment

On admission to the approved centre, the service user should immediately undergo a holistic assessment of their abilities, challenges, issues or identified needs. This process should include the admitting doctor interviewing the service user, preferably with the admitting nurse also in attendance. A risk assessment, mental health assessment, physical assessment, and psychosocial assessment should also be carried out. The information gathered from these assessments and the initial interview with the service user (who may be in a distressed state) must inform an interim care plan.

A care plan cannot be formulated until all necessary assessments are completed. It is important to note that you cannot plan care and treatment if you have not assessed the care and treatment that is required for the service user who has presented themselves, or who has been presented, to your service. Care planning always requires the collection of relevant information.

On admission

The interim care plan must be completed by the admitting doctor and nurse in order to address the immediate needs of the service user. When the members of the MDT meet the service user, they may make some additions and changes to the interim care plan.

They should not wait until the weekly review meeting to prepare the ICP.

Take the following example: the service user has a history of self-harm. As a result, their immediate needs may be focused on safety. Is a certain level of observation required? Perhaps the person cannot, or chooses not to, communicate verbally. If so, this must be documented in the interim care plan, clearly stating, for example: “The person cannot, or chooses not to, communicate at present.” Because the service user has a previous history of self-harm, this must also be documented in the interim care plan. In cases where there is a history of assault, any interventions that help the service user manage this behaviour should also be recorded, and any known triggers highlighted. Finally, if the service user has a known physical health problem, such as diabetes, this must be documented in the ICP.

There is also a critical link between completing a risk assessment and other necessary assessments and formulating the ICP. A period of 7 days of assessment is permitted by the MHC for the interim care plan to be fully expanded into an MDT ICP which guides care for the service user. This 7-day assessment period applies to all approved centres providing both acute and continuing care.

As there is a requirement to have an ICP developed within 7 days of the service user's admission, co production of the ICP will necessitate several meetings between members of the MDT and the service user. Formal and informal assessment must continue throughout this time.

The assessment phase continues throughout the service user's stay in an inpatient service and, where applicable, it may also extend to involving the community mental health team in the assessment process.

Assessment can involve family members and/or the service user's advocate/carer. Assessment also identifies risks and indicates how these risks will be managed and reviewed. Assessment, including risk assessment, balances safety and effectiveness with the service user's right to make choices, taking into account their capacity at this time to make those choices and their right to take informed risks.

When carrying out the initial assessment, members of the service user's MDT should include questions about family, friends and key personal contacts. In addition, a full discussion should take place with the service user around the nature and level of contact with family and friends, and the service user's consent must be obtained with regard to the information that can be shared with family members. The discussion with the service user will explore the benefits of involving family members and supporters such as carers/advocates, however, in certain circumstances, the involvement of particular individuals may not have a positive influence on the service user's recovery.

Points to note: All MDT members who assess the service user during the first 7 days after admission should record in the ICP details of the service user's challenges, issues or needs; goals; interventions; and resources. These entries should be dated, and should contain relevant dates. The MDT members should also record progress in the ICP, including evidence of the implementation of interventions carried out to achieve specific service user goals.

Where a particular challenge, issue or need has been identified, the ICP must state what approaches will be used to address this.

The ICP could also refer to particular abilities that the service user has which can be maintained while they remain in the approved centre.

Discharge planning as part of the assessment process

As soon as practicable following the admission, the MDT – in collaboration with the service user and their family/carer/advocate (where applicable and with the consent of the service user) – should commence the process of discharge planning. It is important to identify any potential challenges or issues surrounding the service user's discharge as soon as possible; this will allow action to be taken to address challenges and issues and prevent the possibility of a delayed discharge. A proposed discharge date should be decided with the patient where appropriate, and this should be documented in the MDT ICP.

Criterion 2
Full MDT ICP in place within 7 days

On and after the 7-day period following admission, a full MDT ICP must be in place. This applies to all approved centres providing acute and continuing care. Obviously, the MDT may meet before the 7-day time limit, and a full MDT ICP may be completed before then, based on the information collected. Ongoing challenges, issues and needs are added to the MDT ICP as they emerge.

Criterion 3
Service user involvement

As highlighted throughout this document, service user involvement is a prerequisite for care planning. The person receiving the care and the MDT should be encouraged to work in partnership with each other where possible. In order to deliver a recovery-oriented service, practice should always be directed towards facilitation or resumption of the service user's own decision-making in all aspects of their life so as to support them in achieving personally defined goals.

Where a person is unable to represent their own views at any given time during their contact with mental health services, the onus is on the service to ensure that 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 they are to be committed to the outcome of the process. Collaborative partnership with the service user is central to recovery and creates a relationship that is strengths focused and is based on openness, equality, power sharing and reciprocity.

Working in partnership with the service user means that the remaining components of care planning – i.e. assessment, identification of need, appropriate goals, implementation, monitoring, review, and discharge planning – are valid and meaningful processes.

Questions which may support service user participation in their care process

Give the person an opportunity to tell their story.

- **How did they get here?**
- **How does the person understand what is going on for them and their mental health challenges?**
- **How do they think the service and the MDT can help them?**
- **What things did they find helpful when dealing with similar challenges in the past, or what do they think might be helpful now? (you may begin from a strengths focus)**
- **How will overcoming or managing their mental health challenges improve their life? (leading on to goal setting)**

If they wish to do so, the service user should be involved in co-producing all elements of their MDT ICP. The service user should be supported to make informed choices at all stages of the process. Where a service user has been detained under the Mental Health Act, 2001, their choices must still be respected as much as possible. Staff should support the service user to feel safe expressing their needs and concerns.

Criterion 4
MDT input developed and reviewed

The Mental Health Act 2001 (Approved Centres) Regulations 2006 Regulation 15 states: "Individual care plan means 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."

The members of the MDT do not need to wait 7 days before beginning to formulate the MDT ICP. This is an ongoing process, which sees the ICP being continually developed and reviewed throughout the service user's stay.

The MDT ICP development and review process must involve the service user unless they have stated that they do not wish to be involved.

The service user's statement that they do not wish to be involved in the care planning process must be documented. This must be an informed choice and the documentation should record how the person was communicated with in relation to the importance of participating in their care planning, and how they were supported and encouraged to do so.

Other individuals, such as a family member, carer or advocate, may be involved in care planning with the service user's consent.

Who should attend MDT ICP meetings?

The composition of the MDT is based on the service user's assessed needs. If possible, all members of the MDT should be present at the service user's first MDT review. But if that is not possible, then a minimum of three health professionals must attend the meeting.

If a specific health professional – such as a psychologist – is not required for the service user's care and treatment, then it is not always necessary that they attend the MDT ICP meetings; their attendance is required only if the service user has an assessed need for such a health professional.

Criterion 5
Appropriate goals for the resident

The Mental Health Act 2001 (Approved Centres) Regulations 2006 Regulation 15 states: "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".

During or following assessment, appropriate goals for the service user should be co-produced with the service user and documented in the ICP. The identified MDT member or key worker and the service user should collaborate to establish more precise targets for each of the goals.

These goals should be specific, measurable, attainable, relevant and time bound; examples are outlined in Table 2.

Once they have been established, the challenges, issues, identified needs, goals and interventions should be recorded in writing, together with details of the resources or MDT member allocated to oversee the interventions.

Table 2: Supporting service users in setting realistic goals

Goals must be important to the person.	It may be a life goal, a treatment goal, or a goal to improve the quality of the person's life.
The number of goals must be manageable.	Sometimes people articulate too many goals and sometimes none at all. The most effective approach is to prioritise and identify just a few key goals.
Goals must be time bound.	Goals may be set for a shorter or longer period of time. This would depend on the individual's personal preferences and current priorities.
Goals must be attainable and realistic.	The identified goal should be as attainable and realistic as possible. But even a goal that is most likely unattainable should not be disregarded until the service user has done some initial work towards achieving that goal.
Work with strengths to overcome barriers to achieving goals.	Once goals have been selected, the next step is to identify strengths that can help the person achieve the goals and overcome the barriers that may be restricting their ability to achieve them.
Add objectives to goals.	It is important to examine the selected goals and separate them, break them down into smaller action steps or objectives. This helps to maintain momentum and build confidence through some short-term achievements.

Criterion 6
Care and treatment to meet goals

The Mental Health Act 2001 (Approved Centres) Regulations 2006 Regulation 15 states: “The individual care plan shall specify the treatment and care required which shall be in accordance with best practice”.

The care and treatment or interventions must meet the service user’s individual goals to address the challenges, issues or identified needs. It is perfectly acceptable to list these interventions in bullet points. However, they must not comprise mere standalone words; they must be phrased clearly in such a way that makes sense to both the service user and the MDT and they must include each of the steps that will be taken in order to meet the goals. Sample wording is provided on page 44.

Criterion 7

Resources to provide care and treatment

The Mental Health Act 2001 (Approved Centres) Regulations 2006 Regulation 15 states: "The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources".

The resources available to both the MDT as a whole and the service user help us to implement the interventions required. The question that should be asked is: Who is going to do what in order to achieve the goals?

Resources are delivered using the skills of the individual MDT members. For example, where a challenge, issue or identified need relating to anxiety has been identified, the service user might be assisted to identify the trigger points that cause their anxiety, and then develop solutions to cope with it.

Another resource may be the key nurse who has the most frequent contact with the service user. Working in consultation with the occupational therapist, the key nurse may facilitate an anxiety management group in line with Regulation 16, Therapeutic Services and Programmes. Subsequently, the occupational therapist and the service user may co-produce a specific individualised anxiety management plan for implementation during the service user's stay in the approved centre.

Because the service user is a resource and is also involved from the outset in the process of care planning, this reinforces their sense of personal responsibility. Moreover, it helps them to reflect on each stage of their progression and recovery.

Online support and group activities in the approved centre may also be of assistance to the service user. And as recovery progresses, the service user themselves may become the primary resource for managing a particular intervention, with assistance provided where necessary by an appropriate member of the MDT. For example, a social worker may assist with housing and an occupational therapist may assist with anxiety management.

Criterion 8

Reviewed within a specified time frame – every 7 days for an acute episode, and every 6 months for continuing care

Care planning is an evolving process, facilitating adaptation and change. It must include a pre-scheduled evaluation of the ICP that is co-produced with the service user. Unscheduled evaluation of a care plan may also be required, as clinically indicated. This documented review process should involve the service user, the key worker, and the MDT. The ICP must be reviewed weekly in acute care approved centres, and at least every 6 months in continuing care approved centres.

Discharge planning must also be a recurring item in the review process. Discussions between the MDT and the service user in relation to this must be clearly documented in the review section of the MDT ICP.

Following completion of the first full MDT ICP within 7 days after admission, a further MDT review of the ICP must take place weekly after completion of the full ICP in acute care approved centres, and at least every 6 months in continuing care approved centres.

In short, the service user must have an interim care plan completed on admission. An ICP must then be prepared within 7 days of admission (a requirement for all approved centres), and thereafter a regular MDT review of the ICP must be carried out. 'Regular' MDT review means weekly for an acute care approved centre or at least every 6 months for a continuing care approved centre.

All new challenges/issues/identified needs and goals with interventions should be documented in the original full ICP. New goals should not be documented in the review section but may be recorded in the review section as having come to light during the review of the ICP.

Where goals are addressed, achieved or are no longer applicable, this should be recorded in the review section and the date should be noted as having been achieved or being no longer applicable in the original ICP.

During the MDT ICP review, in order to assess whether the ICP goals and interventions have been achieved, and if not, why not, the MDT may:

- Examine the reasons for progress or the barriers to progress, if any.
- Evaluate the quality of care provided.
- Reassess current needs.
- Revise care plan goals and interventions.
- Set the date for the next MDT ICP review.
- Record the outcome of the MDT ICP review. This may address issues such as whether a new challenge, issue or need has been identified, or whether a previous challenge, issue or identified need has been resolved.

Criterion 9
Composite set of documentation

The ICP must be recorded in a composite set of documentation. As per the *Judgement Support Framework,* sections 4.1.1 to 4.1.5, this should:

- include allocated space/sections for goals, treatment, care and resources required
- include allocated space/sections for reviews
- be stored in the clinical file
- be identifiable and uninterrupted
- not be amalgamated with progress notes.

The ICP must be recorded in a composite set of documentation stored within the service user's clinical file.

Criterion 10
Education requirements (children only)

Adult inpatient units should include education requirements for children as part of the MDT ICP. This is because on rare occasions, a child may be an inpatient in an adult unit for a long period of time.

The psychiatrist states that the child is too unwell to attend education where this is the case. This must then be documented in the ICP.

Additional points to consider for improving the care planning process:

- **Care planning should be implemented in line with Regulation 15.**
- **Staff should receive training on care planning. This should also include hearing from a person with lived experience of mental health difficulties.**
- **A scheduled auditing process should be applied to care planning, and improvements should be made as a result of such audits.**
- **Relevant written information on the ICP should be available to each service user.**

Part 2

Person-centred care planning in practice

Part 2
Person-centred care planning in practice

Part 2 of this document provides practical examples of how to meet the criteria for compliance with Regulation 15, Individual Care Plan. Such examples and scenarios are for illustrative purposes only and are designed as an aid to enhance the practice of care planning.

Table 1: Criteria for compliance with Regulation 15, Individual Care Plan

1. **ICP in place (interim)**
2. **Full MDT ICP in place within 7 days**
3. **Service user involvement**
4. **MDT input developed and reviewed**
5. **Appropriate goals for the resident, not the treating team**
6. **Care and treatment to meet goals**
7. **Resources to provide care and treatment**
8. **Reviewed within a specified time frame – 7 days for an acute episode, and every 6 months for continuing care**
9. **Composite set of documentation**
10. **Education requirements (children only)**

Criterion 1
ICP in place (interim)

An interim care plan must be in place for the service user immediately after their admission to the approved centre. This plan must be based on the admission assessment and risk assessment.

Scenario 1

In this example, the service user, John, did not want to be admitted to hospital. Both his family and his general practitioner (GP) were concerned about him. He was hearing voices telling him to harm himself. He had locked himself in his room. His sister and the GP stated to the consultant psychiatrist on call at the approved centre that John was not currently aggressive or violent. An insulin-dependent diabetic, he had not eaten for a full day. The assisted admissions team arrived at John's home, where they were met by his sister, and then accompanied John to the approved centre.

On arrival at the acute admissions unit John said he was relieved to have been admitted and he thanked the members of the admissions team for enabling him to avoid having to make the decision to be admitted to the approved centre. He stated to the admitting doctor and nurse that he was feeling depressed and had thoughts of self-harm and suicide. He spoke about hearing voices that were telling him to harm himself. In order to complete the approved centre's risk assessment, the risk assessment that had already been completed by the assisted admissions team aided the reassessment of risk on admission to the approved centre, together with the information that John had given the admitting doctor and nurse.

Example 1: Sample of standardised risk assessment taken from an Assisted Admission Risk Screening Form

Violence	Yes	No	Not Known	Suicide	Yes	No	Not Known
Is there a significant past history of violence?		No		History of previous significant suicide attempts?	Yes		
Current thoughts, plans or symptoms of violence?		No		Thoughts or plans which suggest suicide?	Yes		
Current behaviour suggesting there is a risk of violence?		No		Current behaviour suggesting there is a risk of suicide?	Yes		
Appears to suffer from a major mental illness, with symptoms of paranoia, delusions or hallucinations?	Yes			Appears to suffer from a major mental illness, with symptoms of paranoia, delusions or hallucinations?	Yes		
Current challenges with alcohol or substance misuse?			Not known	Current challenges with alcohol or substance misuse?			Not known
An expressed concern from others about a risk of violence?		No		An expressed concern from others about a risk of suicide?	Yes		
Is it the opinion of the registered medical practitioner (RMP) or general practitioner (GP) that there is a risk of violence?		No		Is it the opinion of the registered medical practitioner (RMP) or general practitioner (GP) that there is a risk of suicide?	Yes		
Medical risks: Are there any known medical risks to be considered prior to/during the assisted admission? (Please detail.)							
John has type 1 diabetes and self-administers insulin twice a day. He takes blood sugar readings every 4 hours on his personal glucometer at home.							
Other risks: *Taking into account other relevant information and the extent of the information available to you, are there other risks that you are concerned about? (e.g. access to firearms, potential weapons)*							
None known							

The information obtained from John, together with the information in the risk assessment screening tool, forms the basis for the interim care plan completed on admission.

Information under all headings (Date, Number, Challenge/Issue/Identified need, Goal, Intervention, Resource/Person responsible, and Review date), as identified in Example 2, must be included in the interim care plan. Identified need in the examples, refers to identified issues/challenges and needs.

Resources in Example 2 refers to the name and the discipline carrying out the intervention.

Example 2: Interim care plan (work in progress)

Date	Number	Identified need	Goal	Intervention	Resource	Review date
19 March 2020	*1*	*John states that he feels like harming himself.*	*Ensure that John is safe at all times.*	*Place John on "Level One" observations to ensure his safety and well-being.*	*Key nurse*	*22 March 2020*
19 March 2020	*2*	*John says, "I'm hearing voices that tell me to harm myself and they get worse at night."*	*"I want the voices to go away."*	*John to take the prescribed medication* *John to attend the 'Hearing Voices' group in the Occupational Therapy Department.*	*Key nurse* *NCHD (Rebecca)* *Service user (John)* *Occupational Therapist (Jake)*	*26 March 2020*
19 March 2020	*3*	*John has type 1 diabetes, with a history of sudden lows in his blood sugar.*	*Ensure that John's blood sugar levels are maintained at normal levels.*	*Ensure that John is given his insulin Sub Cut, as prescribed, twice daily.* *Ensure that insulin is administered 30 minutes before breakfast and 30 minutes before evening meals.* *Monitor blood sugar levels using glucometer every 4 hours and maintain records.* *Commence John on fluid input/ output chart.*	*Key nurse* *NCHD (Rebecca)* *Key nurse*	*26 March 2020*

Over the next few days, a series of continual assessments are carried out by individual members of the MDT – such as a nurse, doctor, occupational therapist, psychologist, social worker, speech and language therapist, dietician, or nutritionist. As outlined on page 11 of the *Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services* dated April 2012, "*Many individuals will have a role in the development of care plans."* Any challenges, issues or needs that are identified by an individual member of the MDT during their assessments are recorded in the ICP.

Criterion 2
Full MDT ICP in place within 7 days

A fully integrated MDT ICP must be in place for the service user 7 days after their admission to the approved centre.

Details of the assessment of challenges, issues or identified needs must be noted prior to completion of the full MDT ICP.

Examples of how to document challenges, issues or identified needs

These examples are service user centred. They are linked to the service user's goals in relation to how they experience their mental health condition and what meaning it has for them.

Where possible, the description should reflect the words used by the service user.

Do not use the description 'Relapse of psychotic symptoms'. Instead, use the style:

- Mary believes she has special powers and believes she knows what people are thinking and feeling. She believes her neighbour is going to be her future husband.

  or

- "I have special powers. I know what people are thinking. My next-door neighbour wants to marry me."

Do not use the description 'Deterioration in mental health presentation'. Instead, use the style:

- Anne has not been sleeping for the past month. She says she is high and overactive and believes people are stealing her clothes.

  or

- "I haven't been sleeping for the past few weeks. I feel really great though. Really, really great. People are stealing my clothes because they want to be like me."

Do not use the description 'Depression and suicidal ideation'. Instead, use the style:

- Tom says he is low in mood and has active thoughts of killing himself.

  or

- "I'm really down. I want to end it all. I want to top myself."
- "I want the voices to go away."
- "I want to feel better."

Scenario 2

Doreen is a 66-year-old woman with a long history of bipolar affective disorder who has recently been transferred from long-term care and treatment in a community residence to an approved centre. Recently, Doreen has experienced some falls and she has difficulty climbing the stairs in the community residence. Since admission, Doreen has become increasingly confused. She has no contact with any family members. She stated immediately following her admission, before her increasing confusion, that she realises she may need to go into a nursing home, but she is desperately sad that her life has come to this.

Doreen has been an inpatient for the past 5 days. She has had a risk assessment carried out. The risk assessment has identified that she poses no risk of harm to herself or others. She has had a number of other evidence-based assessments carried out and there is an ICP in place. Today is Tuesday and her MDT is meeting with her to discuss her care and treatment.

The following are aspects of a falls risk assessment, which, together with Doreen's participation, will help her plan her present care and treatment:

Example 3: Falls risk assessment

Risk for falls assessment tool

Directions: Place a check mark (√) in front of elements that apply to your client. The decision of whether a client is at risk for falls is based on your nursing judgement.

Guidelines: A client who has a check mark (√) in front of an element with an asterisk (*), or who has four or more other elements, would be identified as being at risk for falls.

Tool 1 Risk assessment tool for falls

General data:

- [x] Aged over 60
- [x] History of falls before admission*
- [ ] Smoker

Physical condition:

- [x] Dizziness/imbalance
- [x] Unsteady gait
- [ ] Diseases/other challenges affecting weight-bearing joints
- [ ] Weakness
- [ ] Paresis
- [ ] Seizure disorders

Impairment of:

- [ ] Vision
- [ ] Hearing

Mental status:

- [x] Confusion/disorientation
- [ ] Impaired memory or judgement
- [ ] Inability to understand or follow directions

Medications:

- [ ] Diuretics or diuretic effects
- [x] Hypotensive or CNS suppressants (e.g. narcotic, sedative, psychotropic, hypnotic, tranquilliser, antihypertensive, antidepressant)

Ambulatory devices used:

- [x] Cane
- [ ] Crutches
- [ ] Walker
- [ ] Wheelchair
- [ ] Geriatric (geri) chair
- [ ] Braces

Adapted from Brians LK and others. The development of the RISK tool for fall prevention, Rehabil Nurs 1991; 16 (2):67–69.

Following completion of the above assessment, a challenge or identified need of the risk for falls must be recorded in the ICP.

Example 4: ICP developed when the patient is at risk for falls

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
19 March 2020	*1*	*Doreen has a history of falling and remains at risk due to her unsteady gait and periods of dizziness and confusion.*	*Doreen will be free from falls during her stay in (insert approved centre name).*	*Ensure that Doreen uses her cane at all times.* *Ensure that all essential, everyday items are within Doreen's reach.* *Doreen will take prescribed medication.* *Doreen will avail of daily physiotherapy to improve her gait.* *Assess Doreen's need to use the bathroom every 2 hours.*	*Key nurse* *Service user (Doreen)* *Key nurse* *NCHD (John)* *Key nurse* *Physiotherapist (Mary)* *Key nurse*	*26 March 2020*

Criterion 3
Service user involvement

"…so far as practicable in consultation with each resident." Where 'in consultation' is referred to, this means co-production of the ICP by the service user and the MDT.

Regulation 15 allows for choice. The service user may not wish to be involved in their ICP, or they may be too ill to be involved; for example, they may be severely depressed and may not be able to be involved.

Service user involvement must be documented. If they are not involved, then the reason why this is so must be documented. If the person has chosen not to participate in the care planning process, then the measures taken to encourage their involvement must also be documented.

Recovery terminology such as 'co-production' should be used.

The ICP should be co-produced by the MDT and the service user, as well as a family member or advocate, where applicable.

There are many ways in which the key worker can co-produce the ICP document with the service user. This may be at the ICP meeting or prior to the meeting, using weekly expectation sheets, for example.

Where the ICP states: "ICP discussed with the service user – Yes/No" or "I have been involved in my ICP – Yes/No", you should change this to read: "ICP co-produced with the service user – Yes/No". If 'No' is ticked or circled, then the reason why must be documented.

Communication with the service user prior to the ICP meeting

Example 5

The questions listed below are not exhaustive. Approved centres may already have their own information gathering template, similar to the one shown here.

How are you feeling today? (Consider your mood, appetite, sleep, energy, and how your thoughts are.)
Do you have any worries? (For example, any stressful events, or worries with regard to relationships, friends, family, money, drugs, or alcohol)
Do you feel the goals set with you were achieved?
Do you feel you are recovering? What can we do to help? (If you feel you are recovering, say why. If you feel you are not recovering, say why not and say what would help. What do you hope to achieve from admission?)
What are your goals for this week? (Consider therapeutic programmes, medication, staying well.)
Do you have any concerns on leave/discharge from the unit?
Is there anything else we should know?
Do you wish to have input from a representative, family member, friend, carer, or significant other? Yes ☐ No ☐
Would you like to attend your ICP meeting? Would your family or a friend like to attend?

Service user's signature: _____ Date: _____

(If not signed by the service user, please explain why on the line below.)

_____

Key worker's signature: _____ Date: _____

Key worker's name (block capitals): _____

The weekly expectation sheet is a good medium for helping the service user to focus on and articulate their identified challenges, issues or identified needs, so that these can be discussed at the weekly MDT ICP review meeting.

Ideally, the sheet should be completed in conjunction with the service user the day or evening before their MDT ICP review. Some service users may prefer to complete it alone, or not to complete it at all. Remember, there is no onus on the service user to participate in the care planning process.

The sheet may serve as a good prompt for the service user and they may wish to bring it to the MDT ICP review meeting so that they can easily refer to it.

ICP challenges, issues, needs and goals should be written in the voice of the service user and in conjunction with the service user, where practicable. This process should be completed prior to the MDT meeting.

Scenario 3

What if the service user is unable to identify a challenge, issue or need? Or what if their identified challenge, issue or need differs from that identified by the MDT?

If a service user lacks the capacity to co-produce their ICP with the MDT, then it is best to involve a family member, carer, close relative or service user advocate who may be able to help with the identification of valid challenges, issues or needs. If a service user is assessed as being too ill (e.g. depressed), if they are experiencing a period of mania, or if they refuse to be involved in co-producing their ICP, this must be documented in the ICP by, for example, by their consultant psychiatrist or key worker. In such instances, the statement would read, “At the moment, John is too clinically unwell to be involved in co-producing his care plan”, or “John refuses to co-produce (or be involved in the development of) his ICP.” In either circumstance, the MDT must then proceed to develop an objective ICP based on the assessed challenges, issues or needs of the service user.

It is important to remember that the ICP must be reviewed by the service user’s MDT weekly in the case of an acute care approved centre and at least every 6 months in a continuing care approved centre. There must be documentary evidence to show that the MDT has made genuine attempts every week or every 6 months (depending on the category of approved centre) to involve the service user in the co-production of their ICP.

Where a service user has previously stated that they do not wish to be involved in this co-production, for reasons including that they are happy with their care and treatment, it is nonetheless essential to document the MDT’s weekly/6-monthly attempts to involve them.

Example 6: ICP written in the voice of the service user

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
12 April 2020	*1*	*"I'm really down. I just feel there's no point in going on anymore."*	*"I want to feel better."*	*James to take the prescribed medication.* *Inform and provide James with information about the medication and how it might help him.* *Place James on "Level One" observation.* *Explain to James the reason for this intervention.* *Discuss with James whether he would like to agree specific times to meet to develop a focused plan to achieve his goals.* *Continually assess James's potential for self-harm.*	*Key nurse* *NCHD (Mazin)* *Key nurse* *Key nurse* *Key nurse* *NCHD (Mazin)*	*14 April 2020*
12 April 2020	*2*	*James says he is having recurrent, intrusive and distressing thoughts and impulses of harming himself.*	*To assist James to gain an understanding of, and manage, recurrent distressing thoughts and impulses to self-harm.*	*Help James to normalise his experience by providing him with psychological education around this need.* *Actively encourage and engage James in exposure exercises with the aim preventing previously unhelpful responses.*	*Clinical Psychologist (Joan)* *Clinical Psychologist (Joan)* *Service user (James)*	*19 April 2020*
12 April 2020	*3*	*James says he feels worthless.*	*"I want to feel worthwhile again – the way I used to feel."*	*Explore with James what his interests are. For example, what gave him a sense of enjoyment and value in the past?* *Find out what he felt good at doing.* *James will attend weekly occupational therapy self-exploration and task groups to recognise and deal with negative emotions, develop an awareness of personal strengths, and expand his coping style.*	*Occupational Therapist (Liam)* *Service user (James)* *Occupational Therapist (Liam)*	*19 April 2020*

Example 7

Week 1

ICP co-produced with the service user: ☐ Yes ☑ No

If no, please explain why:

Mary states that she does not want to be involved in the co-production of her care plan.

Date the ICP was co-produced with the service user: N/A

Copy of the ICP given to the service user: ☐ Yes ☑ No

If no, please explain why:

Mary stated that she did not want to receive a copy of her care plan.

Week 4

ICP co-produced with the service user: ☑ Yes ☐ No

If no, please explain why:

Date the ICP was co-produced with the service user: 7 October 2020

Copy of the ICP given to the service user: ☑ Yes ☐ No

If no, please explain why:

Scenario 4: Co-production

The service user (Angela) was offered a copy of her ICP. If she did not take up this offer, state the reason why. Provide documentary evidence as to why Angela did not wish to take a copy of her ICP.

Do not just write 'refused'.

Instead, write the stated reason in a couple of sentences.

Example 8

ICP co-produced with the service user: ☐ Yes ☑ No

If no, please explain why:

Angela stated: "I want nothing to do with my care plan."

Date the ICP was co-produced with the service user: N/A

Copy of the ICP given to the service user: ☐ Yes ☑ No

If no, please explain why:

Angela declined a copy of her ICP when it was offered to her on Monday 22 March 2020 at 9.20 am.

Example 9

ICP co-produced with the service user: ☑ Yes ☐ No

If no, please explain why:

Date the ICP was co-produced with the service user: 7 October 2020

Copy of the ICP given to the service user: ☐ Yes ☑ No

If no, please explain why:

James was happy not to accept a copy of his ICP, but asked if he could view it weekly in his clinical file with his key worker.

Example 10

ICP co-produced with the service user: ☐ Yes ☑ No

If no, please explain why:

Catherine is currently in seclusion.

Date the ICP was co-produced with the service user: N/A

Copy of the ICP given to the service user: ☐ Yes ☑ No

If no, please explain why:

Catherine is currently in seclusion, and therefore a copy of her ICP was not offered to her at this time. A copy of her ICP will be offered to her at a more appropriate time for her. (Insert the suggested date given to Catherine.)

This information is followed up and documented at each subsequent regular (weekly/6-monthly) MDT ICP review meeting.

Criterion 4
MDT input developed and reviewed

"…developed, regularly reviewed and updated by the resident's multi-disciplinary team…"

The *Judgement Support Framework* defines 'regularly reviewed' as:

- **weekly in an acute setting approved centre (seven days)**
- **6-monthly in a continuing care setting approved centre.**

The MDT review involves an evaluation of the ICP (see Appendix 1 for an example of an MDT ICP review meeting template). While the review process does not involve rewriting the ICP in its entirety every 7 days or every 6 months (depending on the type of approved centre), it is nonetheless important to document each new challenge, issue or need, together with its corresponding goal for the service user, the interventions and the resource(s), in addition to documenting the proposed date when the next review will be carried out.

MDT developed

During the assessment process, which must be continuous, a member of the MDT (such as the key nurse) – or the service user, a member of their family, their carer, or a service user advocate – may identify one or more service user challenges, issues or needs. These may also be identified during the risk assessment, or during one-to-one conversations with the service user. As part of the assessment process, the service user will tell their story, explaining why they think they are in the approved centre; sometimes a family member may also be involved in these discussions. In circumstances where the service user lacks the capacity to be involved in the care planning process, a member of the MDT and a member of the service user's family may be involved in these discussions.

The identified challenges, issues or needs that arise out of the various assessments, including the risk assessment and the conversations between the service user and the individual MDT members, must be noted in the ICP.

The challenge, issue or need identified; the service user's goal; the intervention; and the resource (discipline/person responsible) must all be documented in the ICP. The date of the expected outcome to address the challenge, issue or need identified should be documented. The date for the MDT review to address the challenge, issue or need identified should also be documented. (This review must take place every 7 days in an acute care approved centre, and every 6 months in a continuing care approved centre.)

On a given afternoon, the occupational therapist may meet the service user. Following their assessment, they may, together with the service user and a family member, carer or advocate, identify a new challenge, issue or need. The occupational therapist will then document these details in the ICP along with details of the service user's goal, the occupational therapist's and the service user's intervention, and the resource (discipline/person responsible, in this case, the occupational therapist).

Alternatively, the occupational therapist may read the challenge, issue or need identified by the nurse and the service user, and may then contribute to that by adding an extra intervention in the ICP, stating, for example, that the occupational therapist, Jane, will be the designated resource to oversee that particular added intervention.

Note: as per page 11 of the *Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services,* dated April 2012, ***"Many individuals will have a role in the development of care plans."***

The **MDT review** must take place weekly in an acute care approved centre and at least every 6 months in a continuing care approved centre, **or sooner should a new challenge, issue or need for the service user present itself or be determined during an assessment.**

Should a new challenge, issue or need be identified, you should not wait until the next MDT review to add those details to the service user's ICP; rather, you should note it in the ICP the same day.

The ICP guides care and treatment.

The MDT review is an evaluation of the service user's particular challenge, issue or need resulting from an evidence-based assessment, and following a conversation between the service user and the MDT.

At least three members of the MDT should be involved in the weekly MDT review, and preferably the entire MDT should be involved in the service user's care and treatment. If a particular member of the MDT, for example the psychologist, does not have an input into the service user's ICP, then the psychologist does not have to attend that particular service user's MDT review.

If there is an identified need to involve, for example, a psychologist or dietician in a service user's care, and neither a psychologist nor a dietician is available to the MDT, then that unmet need must be documented in the ICP and the MDT must make every effort to acquire the services of a psychologist or dietician.

MDT care planning is based on the assessed needs of the service user. For example, if an intervention is delivered by a dietician, physiotherapist or speech and language therapist, these interventions must have resulted from an assessed challenge, issue or need. Consequently, the care plan must be designed around these interventions and must be documented in the ICP.

Any new challenge, issue or need identified must be documented in the ICP rather than on the weekly/6-monthly MDT review sheet. However, the fact that a particular challenge, issue or need has been identified should be noted in the MDT review sheet. Similarly, any challenge, issue or need that is no longer valid, or has been resolved, must be documented as such in the weekly/6-monthly MDT review sheet. It must also be documented in the ICP as having been resolved, and then dated and signed by a member of the MDT.

Specific challenges, issues or needs must be identified and documented in the ICP instead of using broader terms such as 'BPAD', 'dementia', 'psychosis', 'mental health issues', or 'physical health'. So rather than writing 'dementia', use 'poor communication', 'aggression', or 'agitation'. For example, write: "John tends to pace up and down in his room at night" or "Inability to get to sleep at night".

Once a specific challenge, issue or need has been identified, it is much easier to identify the specific goal related to that challenge, issue or need.

Example 11 and example 12 focus on physical health in the context of a continuing care approved centre. In this example, it is best to create a separate entry for each specific physical health need in the "Issue" column, so that the recovery goals and therapeutic interventions are specific to that issue/need.

Example 11

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
19 March 2020	*1*	*John has type 2 diabetes.*				
19 March 2020	*2*	*John is prone to recurrent urinary tract infections (UTIs).*				
19 March 2020	*3*	*John smokes 20 cigarettes a day and is careless about where he puts his cigarette butts.*				

Example 12

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
12 September 2020	1	John has been experiencing chronic neck pain for the past 4 years.				
12 September 2020	2	John suffers from asthma.				
12 September 2020	3	John is prone to recurrent UTIs.				

Do not follow the style used in examples 13, 14 or 15.

Example 13

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
19 March 2020	1	Diabetes Recurrent UTIs Smoker				

With Example 13, it would be difficult to identify clear goals for the service user, as the ICP features three different identified needs in the same column. Therefore, the interventions required to meet each of the goals would be difficult to follow and implement.

Although there is a requirement for 6-monthly reviews in continuing care approved centres, some approved centres undertake an MDT review of the ICP every 3 months and it is recommended that this practice continues.

Criterion 5
Appropriate goals for the resident

"'Individual care plan' means 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."

As already discussed, the identified challenge, issue or need documented in the ICP must be that identified by the service user, and not by the approved centre. When noting these details in the ICP, it is best to use the service user's own language where possible.

Sometimes there is a disconnect between what has been assessed and what has been documented in the ICP. Accuracy is critical. It is essential that the challenges, issues or needs identified during the assessment reflect those documented in the ICP. For example, if the service user states: "I'm hearing voices and they get worse at night", then this identified challenge, issue or need should not be recorded as 'psychosis' in the ICP. Rather, it should be specific and service user focused, and recorded exactly as stated by the service user: "I'm hearing voices and they get worse at night."

The service user's challenge, issue or need must be specific. The more specific the challenge, issue or need documented, the easier it is to identify appropriate goals that relate to those specific challenges, issues or needs. It is also easier to deliver the recovery goal if the various required interventions are documented in the ICP.

Examples of poorly written identified needs:

It would be difficult to identify appropriate goals that relate to the following challenges, issues or needs. See examples 14 and 15.

Example 14: do not follow this example

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
19 March 2020	*1*	*Psychotic*				
19 March 2020	*2*	*Psychological*				
19 March 2020	*3*	*Behavioural*				

Example 15: do not follow this example

Date	Number	Identified need	Goal	Intervention	Resource/ Person responsible	Review date
12 September 2020	*1*	*Psychoeducation*	*Psychoeducation*	*Advice*	*MDT*	*19 September 2020*
12 September 2020	*2*	*Pharmacotherapy*	*Pharmacotherapy*	*Medication rationalisation*	*Doctor*	*19 September 2020*
12 September 2020	*3*	*Ongoing*	*Ongoing*	*Continue medication and monitor*	*Doctor*	*19 September 2020*

Goals should be specific, measurable, attainable, relevant and time bound.

In order to identify goals that are SMART, the challenge, issue or need identified must be specific, and preferably should be stated in the service user's voice.

For example, John says: "The anxiety is still there. I can't get it out of my mind". That is John's specific identified challenge, issue or need from his perspective, and it is appropriate.

Consequently, under the 'Goals' heading, do not write statements such as 'Relieve anxiety and stabilise mental health', as this type of statement is too broad.

It is best to focus on John's specific challenge, issue or need – that is, the anxiety itself – as this is what is distressing him.

Because John's goals are specific, the required interventions can also be easily documented, as long as they too are specific.

Do not write inappropriate, non-specific interventions, such as 'Medications, activities, knitting, nursing' or 'Social work, medication, nursing". None of these are interventions.

See Example 16, where the identified challenge, issue or need is poor self-esteem. In this instance, a member of the MDT asks Mary how she is feeling. Mary replies, "I feel worthless."

Example 16

Date	Number	Issue/need	Goal	Intervention	Resource/ Person responsible	Review date
12 April 2020	*3*	*"I feel worthless."*	*"I want to feel worthwhile again - the way I used to feel."*	*Explore with Mary what her interests are. For example, what gave her a sense of enjoyment and value in the past?* *Find out what she felt good at doing.* *Mary will attend weekly occupational therapy self-exploration and task groups to recognise and deal with negative emotions, develop an awareness of personal strengths, and expand her coping style.*	*Occupational Therapist (Liam)* *Service user (Mary)* *Occupational Therapist (Liam)* *Service user (Mary)*	*19 April 2020*

Example 17: Goals

This example demonstrates how to correctly record the assessed goals

Date	Number	Issue/need	Goal	Intervention	Resource/ Person responsible	Review date
19 March 2020	*1*	*"I'm hearing voices that upset me and they get worse at night."*	*"I want the voices to go away."*	*John to take the prescribed medication.* *Inform and provide John with information about the medication and how it might help.* *John is encouraged to attend the 'Hearing Voices' group when it takes place.* *John will be given information in relation to the 'Hearing Voices' group in the Occupational Therapy Department.* *The occupational therapist will meet with John to explain what happens in the group.*	*Key nurse* *NCHD (Thomas)* *Service user (John)* *Occupational Therapist (Jake* *Occupational Therapist (Jake)*	*26 March 2020*

Example 18

Date	Number	Issue/need	Goal	Intervention	Resource/Person responsible	Review date
23 June 2020	*1*	*Unemployment is placing a strain on Angela and her family.*	*Angela would welcome help to develop a financial plan.*	*A meeting with Angela and Shelagh will be organised.* *Information on entitlements and how to access supports will be provided.* *A follow-up meeting will be organised if Angela has further questions.* *Explore how Angela feels about a referral to a voluntary agency such as the Money, Advice & Budgeting Service (MABS).* *Elicit the support Angela may need in order to self-refer.* *Provide this support.* *Engage with the voluntary agency.*	*Social Worker (Shelagh)* *Service user (Angela)* *Social Worker (Shelagh)* *Service user (Angela)* *Service user (Angela)* *Social Worker (Shelagh)* *Service user (Angela)*	*30 June 2020*

Remember, the goal belongs to the service user, not the mental health service.

Criterion 6
Care and treatment to meet goals

The ICP must specify the treatment and care required, which must be in accordance with best practice.

As required under Regulation 16, treatment and care interventions must include details of the therapeutic services and programmes to be provided, as outlined in the ICP.

Example 19: Interventions to meet the goals

Care and treatment (interventions)	Resources
John will attend the 'Hearing Voices' group on Tuesday and Friday mornings.	*Service user (John)* *Occupational Therapist (Paul)*
John will take the prescribed medication, as administered.	*Service user (John)* *NCHD (Saleh)* *Key nurse*

Care and treatment to meet goals. The interventions should be specific to the service user's goals. **Interventions should be written in a way that guides the care and treatment.** It is best to list these in the way shown in Example 20.

Example 20

Therapeutic interventions	Resources	Review date
John will take the prescribed medication.		
Inform and provide John with information about his medication and how it might help.		
John is encouraged to attend the 'Hearing Voices' group in the Occupational Therapy Department.		
John will be given information on the 'Hearing Voices' group in the Occupational Therapy Department.		

Therapeutic interventions	Resources	Review date
John will take the prescribed medication.		
Monitor John's blood sugar level weekly.		
Implement diabetic diet as per the dietician's plan.		

Further examples of the ICP written in the voice of the service user

Example 21

Date	Number	Issue/need	Goal	Therapeutic intervention	Resources	Review date
12 April 2020	*1*	*"I'm really down. I just feel there's no point in going on anymore."*	*"I want to feel the way I used to feel before my wife died."*	*James to take the prescribed medication.* *Inform and provide James with information about his medication and how it might help.* *Place James on "Level One" observation. Explain to James the reason for this intervention.* *Discuss with James if he would like to agree specific times to meet to develop a focused plan on his goal.* *Continually assess James's potential for self-harm.*	*Key nurse NCHD (Mazin)* *Key nurse* *Key nurse* *Key nurse NCHD (Mazin)* *Key nurse*	*14 April 2020*
12 April 2020	*2*	*James says he is having recurrent, intrusive and distressing thoughts and impulses of harming himself.*	*To assist James to gain an understanding of, and ability to manage, recurrent distressing thoughts and impulses to self-harm.*	*Help James to normalise his experience by providing him with psychological education around this need.* *Actively encourage and engage James in exercises of exposure, with the aim of preventing previously unhelpful responses.*	*Clinical Psychologist (Joan)* *Clinical Psychologist (Joan)* *Service user (James)*	*19 April 2020*

Example 22

Date	Number	Issue/need	Goal	Therapeutic intervention	Resources	Review date
8 October 2019	1	Boris believes that certain numbers he sees on road signs, and certain colours of cars, are connected in some way to his former girlfriend.	Boris says he wants to manage these thoughts and to eventually get rid of them.	Admit Boris to Hi Observation ward Administer medications as prescribed. Monitor Boris's mood and behaviour. Allow one-to-one time with Boris to help him distinguish between real and imaginary thoughts.	Consultant Psychiatrist (Dr A Hamid) Registrar (Shane) Key nurse	9 October 2019
9 October 2019	2	Boris is unwilling to remain in hospital.	Boris has been asked to remain in hospital, but he has refused.	Commence the process of involuntary admission for Boris under the Mental Health Act 2001. Admission Order affirmed Medication administered to Boris as prescribed.	Consultant Psychiatrist (Dr A Hamid) Registrar (Shane) Key nurse	11 October 2019

Criterion 7
Resources to provide care and treatment

The ICP 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.

When 'resources' are referred to in writing, the Inspector of Mental Health Services advises that they should be styled as 'the name and the discipline'. It is acknowledged by the Inspector of Mental Health Services that the exception here is nursing staff due to shift changes etc and in this case, "Key Nurse" or "Primary Nurse" may be used without a name, however, the Key Nurse or Primary Nurse must be identifiable on the day of inspection not only to the inspector but also to the service provider and to the service user. For example:

- Service user (Sean)
- Key nurse/Primary nurse
- Consultant Psychiatrist (Dr P Nally, or Phillip)
- Occupational Therapist (Liam)
- Psychologist (Nora)
- Social Worker (Amira).

In the example described below, the resource (discipline/Person responsible) is the nurse, occupational Therapist and to some extent the service user may also be a resource.

Example 23: Evidence of the resources allocated to meet the assessed needs/goals

Care and treatment (interventions)	Resources
John will attend the 'Hearing Voices' group on Tuesday and Friday mornings.	*Service user (John)* *Occupational Therapist (Paul)*
John will take the prescribed medication.	*Service user (John)* *NCHD (Saleh)* *Key nurse*

Therapeutic intervention	Resources
John will take the prescribed medication.	*NCHD (John)* *Key nurse*
Inform and provide John with information about his medication and how it might help.	*Key nurse*
John is encouraged to attend the 'Hearing Voices' group.	*Occupational Therapist (Anwar)*
Explore how John feels about a referral to a voluntary agency such as MABS.	*Social Worker (Philomena)* *Service user (John)*

Criterion 8

Reviewed within a specified time frame – 7 days for an acute episode and every 6 months for continuing care

Please also refer to Criterion 4 (MDT input developed and reviewed)

"'Individual care plan' means 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 ICP was reviewed and updated by the MDT within the appropriate time frame:

- weekly (7 days) for an acute episode
- at least every 6 months for continuing care.

Point to note: If the MDT meets on a Monday and the service user is admitted later the same afternoon – in other words, after the MDT meeting has taken place – and if the following Monday is a Bank Holiday, then there will be an automatic breach of Regulation 15 if the service user's MDT ICP has not been formulated by that Bank Holiday Monday.

Reason: 8 days will have elapsed before the formulation of the service user's MDT ICP.

- Ensure that the date and time of the MDT ICP review is recorded at the top of the MDT ICP review page.
- The MDT ICP review may be recorded by one person, preferably the key worker.
- The service user's key worker must sign and date the MDT ICP review at the bottom of the review sheet. The names of all members of the MDT who attended the meeting must be included on the review sheet.

All goals that have been achieved and are no longer relevant should be discontinued in the original ICP and referred to in the MDT review sheet in the week when they were discontinued.

- If a new challenge, issue or need is identified at the weekly MDT ICP review, it is important that this is inputted in the ICP and not in the review sheet.
- Once the identified challenge, issue or need has been inputted in the ICP, it should then be noted in the review section of the ICP as having been identified.
- Do not wait for the following scheduled MDT review to update the ICP. If the assessed needs of the service user change, the ICP should be updated on the same day that the particular need was noted. The ICP should always reflect the service user's current needs and should guide their care.

Criterion 9
Composite set of documentation

The ICP must be recorded in a composite set of documentation and must be stored within the service user's clinical file. The progress notes should demonstrate evidence of the interventions implemented to address the goals specified, and should also identify the resources who have completed these interventions. If a goal cannot be met in the service, the evidence of referral to external agencies must be documented in the resident's clinical file.

Criterion 10
Education requirements (children only)

Where the ICP relates to a child, is there evidence that the child's education requirements have been considered during the care planning process?

If a child is admitted to an adult unit, the child's education requirements will be included in both the interim care plan and the full ICP. If the child is unwell and cannot attend education, this must be documented in the ICP.

Appendix 1: MDT ICP Review meetings sample template

Sample for illustrative purposes only

Name	Date of birth	Date of review meeting	Review meeting number
			1

Prior to an ICP review meeting, the service user may document their views and expectations regarding their care plan/treatment	
What are the challenges/issues/needs and concerns for you?	
What would help to assist you in your recovery?	
What would you like to see happen before the next meeting?	
Service user's signature:	Key worker's signature:

PRESENT AT REVIEW MEETING Please tick and include names/signatures				
Service user ☐	Consultant ☐	NCHD ☐	Nurse ☐	Psychologist ☐
Occupational Therapist ☐	Social Worker ☐	Family member/ carer ☐	Advocate ☐	Other ☐

MDT – Review and evaluation summary	
Have restrictive practices used in the previous week been reviewed? Yes / No (circle)	
Has the MPARS/Kardex been reviewed? **Yes / No (circle)**	**Has the ICP been updated?** Yes / No (circle)

Current risk assessment score					
A = Absconsion **V** = Violence **S** = Suicide **F** = Falls **O** = Other **Place the appropriate letter (A, V, S, F, or O) within the risk category rated most appropriate following clinical assessment.**					
Risk	**Category**	**Time**	**Date**	**Assessor**	**Grade**
High – imminent risk of harm/injury to self or others					
Medium – background risk but no imminent risk					
Low – no evidence of risk of harm to self or others					

Does the ICP include the risk management plan?

Leave status

Please circle as appropriate:

No leave / Day leave _____hours / Weekend leave 1, 2, 3 nights / Other nights (specify) _____

Unaccompanied / Accompanied by _____ (Named person)

Does the service user have the capacity to self-administer medication? Yes/No. If "No", who is the named person who will be taking responsibility for administering medication to the service user when they are on leave?

_____

Signed on behalf of the MDT

MDT member: _____ Date: _____

Post-ICP meeting* – Key worker review

* This meeting between the service user and the key worker must take place immediately after the ICP review meeting, or as soon as practicable

Date of meeting with the service user: _____

Offered copy of the ICP to the service user: (Yes / No)

If "No", explain: _____

Signed: (Service user) _____

Signed: (Key worker) _____ Date: _____

Appendix 2: Extract from the Best Practice Guidance for Mental Health Services

Below is an extract from the *HSE Best Practice Guidance for Mental Health Services*. If all sections are complete, the approved centre would be compliant with Regulation 15, Individual Care Plan, and also with the Judgement Support Framework. It is suggested that services review their ICP audit against the points set out below and include those needed as relevant.

Care is planned and delivered to meet the individual service user's initial and ongoing assessed mental health care needs, while taking account of the needs of other service users.

Indicator 2.1

Each service user has an individual care and treatment plan (ICP[2]) that describes the levels of support and treatment required in accordance with his/her needs, and is coordinated by an identified team.

These are the features you need to have in place in order to meet the indicator:

1. There are policies and procedures in place on the development, use and review of the ICP in accordance with the *Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services (April 2012)* and with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15, Individual Care Plan.

2. At a minimum, the policy includes:

   - the roles and responsibilities relating to the individual care planning
   - the comprehensive assessment of service users on admission and on an ongoing basis
   - the required content in the set of documentation making up the ICP
   - the implementation of the ICP reviews and updates
   - the required service user's involvement in individual care planning, where practicable
   - the time frames for assessment, planning, implementation and evaluation of the ICP
   - clarity in relation to the service user's access to his or her ICP.

2 Individual Care Plan

Regulations 3, 5, 7, 8, 11, 15, 16, 17, 19 and 31 of the Mental Health Act 2001 (Approved Centres) Regulations 2006 S.I. No. 551 of 2006.

Mental Health Commission Guidance Document on Individual Care Planning Mental Health Services (April 2012)

Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an approved centre

Mental Health Commission Quality Framework Standard 1.1.

3. The policy and procedures on the ICP are implemented.

4. All clinical staff have read and understand the policy and procedures on the ICP and a record of this is documented.

5. All clinical staff can articulate the policy and procedures on ICPs.

6. All Multi-disciplinary team members are trained on ICPs.

7. A key worker is identified for each service user, in order to ensure continuity in the implementation of a service user's ICP.

8. A pre-admission assessment is carried out where appropriate in order to identify the assessed needs of the service user and to ensure that his or her assessed needs can be met.

9. Each service user is initially assessed on admission. An initial care plan is completed by the admitting clinician, in order to address the immediate needs of the service user. Where agreed by the service user, this is carried out in consultation with the service user, their family, or their carer.

10. Registered Medical Practitioners assess service users' general health needs at admission and on an ongoing basis as part of the service's provision of care.

11. Service users receive appropriate general health care interventions in accordance with his or her individual care plans.

12. Records are available that demonstrate the service user's completed general health checks and the associated results, including records of any clinical testing; for example, laboratory results.

13. The comprehensive assessment completed on admission may include, but is not limited to, the following:
    - views, wishes and preferences of the service user
    - medical, psychiatric and psychosocial history
    - medication history and current medications
    - current physical health assessment
    - nutritional assessment
    - detailed risk assessment
    - social, interpersonal and physical well-being-related issues, including resilience and strengths
    - communication abilities
    - educational, occupational and vocational history.

14. Evidence-based assessments are consistently completed by appropriately trained staff with the required skills.

15. An integrated ICP is developed by the MDT or the service user's support team – with the service user, where practicable – as soon as possible, but within 7 days of admission, following a comprehensive assessment and any immediate interventions required.

16. The ICP identifies the service user's assessed needs.

17. The ICP is discussed; agreed, where practicable; and drawn up with the participation of the service user and his or her representative, family and next of kin, as appropriate, with consent.

18. Where the service user has refused involvement in the individual care planning process, there is documented evidence of this.

19. Appropriate outcome goals are clearly defined in planning care for individual service users.

    These goals are:

    - based on the service user's assessed needs
    - agreed between the service user and the identified lead healthcare professional
    - regularly reviewed and revised to ensure effectiveness
    - regularly reviewed and revised to ensure that they reflect the service user's changing needs and preferences.

20. The ICP identifies the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

21. A child service user's ICP must include his or her education requirements, in accordance with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15, Individual Care Plan, and Regulation 17, Children's Education.

22. The ICP has a relapse prevention focus.

23. The ICP has a recovery focus.

24. The ICP has a strengths-based focus.

25. The ICP identifies the resources required to provide the care and treatment identified.

26. The ICP includes an individual risk and safety management plan.

27. The ICP includes a preliminary discharge plan, where deemed appropriate.

28. The ICP is implemented and monitored by the key worker and other relevant staff.

29. The ICP, including the risk assessments and management plans, is reviewed and updated in accordance with regulatory and best practice requirements, and review dates are set out in the ICP. (Weekly review within an approved centre for an acute admission and at least every 6 months for service users in a continuing care approved centre, or in accordance with the service user's changing needs, condition, circumstances and goals.)

30. The ICP is reviewed by the MDT in consultation with the service user, as far as is practicable. The service user has access to the ICP and is involved with, and informed of, any changes. The ICP is updated as indicated by the service user's changing needs and communicated to relevant staff as appropriate.

31. The service user is offered a copy of his or her ICP, including any reviews; this is documented.

32. When a service user declines or refuses a copy of their ICP, this is recorded, including the reason, if given.

33. The ICP must be recorded in a composite set of documentation stored within the service user's clinical file.

34. The ICP is not amalgamated with progress notes. It should be identifiable and uninterrupted.

35. If the needs of a service user cannot be met within the scope of the approved centre, there must be evidence that the service user was informed and that the necessary arrangements for transfer of care to the appropriate service were made in consultation with the service user.

36. Audits of ICPs are carried out on a quarterly basis and required improvements are documented and implemented.

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