**CARE PROGRAMME APPROACH CARE PLAN**

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| **SERVICE USER DETAILS** |
| Name |  |
| Date of Birth |  |
| Current Address |  |
| Telephone number(s) |  |
| CHI number |  | SW umber |  |
| Gender |  |
| First Language |  |
| Communication assistance required? Please give details |  |
|  |
| **RELATIONSHIP DETAILS** |
| Named Person (most recent info) |  |
| Relationship to service user |  |
| Address |  |
| Telephone Number |  |
|  |  |
| Welfare Attorney/Guardian |  |
| Address |  |
| Telephone number |  |
|  |  |
| Nearest relative |  |
| Relationship to service user t |  |
| Address |  |
| Telephone Number |  |
| **USEFUL CONTACTS** |
| Designation | Name | Office Hours Contact Number | Out of Hours Contact Number |
| Care Coordinator |  |  |  |
| RMO/ Psychiatrist |  |  |  |
| MHO |  |  |  |
| General Practitioner |  |  |  |
| Social Worker |  |  |  |
| Community Nurse |  |  |  |
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| **MENTAL HEALTH ACT DETAILS**  |
| Type of order |  |
| Date order began  |  |
| Date of most recent review |  |
| Next review date  |  |
| **COMPULSORY TREATMENT DETAILS** |
| Compulsory Measures authorised under Mental Health (Care and Treatment) (Scotland) Act 2003 |  |
| Date of T2B / T3B Certificate |  |
| Description of treatments authorised by T2B or T3B certificates |  |
| **ADVANCE STATEMENT** |
| Does the service user have an advance statement? (If yes, detail contents at the end of this care plan) |  |
| **CONSENT TO CPA**  |
| Has the Care Programme Approach been explained to the service user? |  |

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| **CPA ATTENDANCE** |
| **Name & Contact Address** | **Designation**  | **Attended CPA meeting** |
|  | Service user | [ ]  |
|  | Family member(s) | [ ]  |
|  | Welfare Attorney/Guardian | [ ]  |
|  | Named Person | [ ]  |
|  | RMO/Psychiatrist | [ ]  |
|  | MHO | [ ]  |
|  | CPA Coordinator | [ ]  |
|  | Social Worker | [ ]  |
|  | Community Nurse | [ ]  |
|  | Psychologist | [ ]  |
|  | Advocacy | [ ]  |
|  | Occupational Therapy | [ ]  |
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*This section sets out the identified needs in relation to: medical treatment for mental disorder; other forms of treatment; needs in respect of current planned community care; risk management issues; and it should also document any unmet needs. The examples of needs are not exhaustive and additional/alternative headings should be included, as required.*

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| **RECORD OF IDENTIFIED NEEDS AND PLAN TO MEET THESE** |
| **Need** | **Proposed Objective**  | **Action & By whom**  | **Update**  |
| Address mental health issues |  |  |  |
| Address physical health issues |  |  |  |
| Address relationship issues |  |  |  |
| Address occupational and recreational issues  |  |  |  |
| Address self care issues |  |  |  |
| Address other risk issues |  |  |  |
| Develop future plans |  |  |  |
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| **RISK MANAGEMENT/CONTINGENCY PLAN** |
| **Category** | **Relapse Indicators/Early Warning Signs** | **Contingency Actions** |
| **Symptoms of mental illness** | **Green** |  |  |
| **Amber** |  |  |
| **Red** |  |  |
|  |
|  | **Green** |  |  |
| **Amber** |  |  |
| **Red** |  |  |
|  |
|  | **Green** |  |  |
| **Amber** |  |  |
| **Red** |  |  |
|  |
|  | **Green** |  |  |
| **Amber** |  |  |
| **Red** |  |  |

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| **SERVICE USER’S VIEWS** (TO BE COMPLETED BY CPA COORDINATOR AND KEPT IN NOTES) |
| **Patient’s comments on Care Plan** (If no comment made – please state) |  |
| **Service user signature:** |
| **CPA Coordinator signature:** |
| **Date of discussion:** |
| **The Care Programme has been verbally agreed by those involved** |
| **Service User**  |  |
| **RMO**  |  |
| **MHO** |  |
| **CPA Coordinator****(signed on behalf of all consulted)** |  |
| **ARRANGEMENTS FOR NEXT CPA** |
| **Date** |  |
| **Time** |  |
| **Venue** |  |