**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** |  | | |