COCAPP-A Care Plan Review Template

Guidance for completing this form

The aim of this template is to record information on recovery and personalisation in the most recently available care plan for the specified recipient of mental health care. Where possible you should answer all questions. Where there is not sufficient information or clarity then please make a note in the notes box. We have included some guidance on what sort of things you may come across in answer to the elements in the content of the Care Plan. All reference to the person in the document should be taken to mean the recipient of mental health care.

Inclusion of the person's views: look for evidence that the person had a say in the care plan. The ways in which the goals are worded might reveal this. For example 'John would like to stop taking his medication' indicates that this is John's view and it also suggests a view that is not usually evident from workers.

Co-production: is there evidence that goals and treatment plans have been jointly formulated or show a shared ownership of goals and outcomes.

Strengths based assessment: this can be seen in care plans that formulate goals built upon the strengths, skills or talents of the individual. An example might be 'Jane would like to build on her analytical skills by enrolling on a systems analyst training course'.

Personalisation: is there evidence of choice and control for the person over their care and treatment? Are these based upon the person or just what is available? A care plan solely focused upon medication, side effects, symptoms or risk should not be considered to show personalisation as this ignores other types of support.

Personal Budget: these give people control and choice over the purchase of personal social care services to meet their eligible needs. Is there a reference to this or discussion about the use of personal budgets in the care plan?

Recovery oriented practice: does the care plan indicate a focus on building recovery such as facilitating new relationships, assistance with education or return to work, finances or money, personal care or physical well-being or developing a new sense of purpose?

Person centred goals: are the care and treatment goals focused on the person's assessment of their needs?

System based goals: in contrast to the above are the care and treatment goals solely or majorly focused on system needs such as compliance with treatment.

The person's views in risk assessment: frequently people are not asked for their view on risk assessments and many will not be aware they have occurred; where a risk assessment is included are the person's views on this evident in the document?

The person's views in risk management plan: is there evidence that the person has agreed to the risk management plan or has been allowed the opportunity to discuss this and provide their perspective?

The person's views in crisis plan: is there evidence that the person has had a say in the crisis plan, expressed a view on it or indicated their agreement or disagreement with the plan? Please make a note in the notes section to help us understand your response.

The person's views in relapse plan: if there is a relapse prevention plan has this included the person's perspectives?

Orientation to social outcomes: does the plan show a focus on social outcomes such as relationships and social networks or support, housing, work or education? If this is partial please make a note in the notes section.

Orientation to medical outcomes: on balance is the focus on medical outcomes greater or lesser than the focus on personal or social outcomes? Please make a note in the notes section to help us understand this.

Encouragement for self-management: is there evidence that the care plan is encouraging shared responsibility with the person, for instance are there attempts to provide opportunities for the person to create their own plans or goals?

Recognition of personal relationships: is there evidence of a focus on fostering new or maintaining existing relationships?

Advance directives: are there plans for when the person is unable to make known their wishes for treatment? Is this signed and supported by workers?

Discharge Planning: have any plans been documented about discharge planning. Housing needs? Is there any information about what may be needed in supporting the service user in the community? Notes: Please use the notes box beneath questions for adding detail. In the larger notes box it would be useful to give an impression of preponderance in the care plan, is it more focused on recovery and personalisation overall or is does this make up only a small proportion of the whole? Include anything else you feel is directly relevant to the care plan that is not otherwise covered.

COCAPP-A Care Plan Review Template

Reviewer:	Date:				
Client/Site study identifier:					
Gender:	please circle	Male	Female		
Age (in years):					
Date of Admission:					
Is this the first Admission? If no - how many previous admissions?	please circle	Yes	No	_____	
What type of admission?	please circle	Informal	Formal	CTO	Unclear
Care plan signed by service user? If no is a reason given?	please circle	Yes	No		
Care plan signed by named nurse?	please circle	Yes	No		
Care plan given to the service user?	please circle	Yes	No		Unclear
At the last ward round:					
Was the person present?	please circle	Yes	No		Unclear
Was a carer present?	please circle	Yes	No		Unclear
Was an advocate present?	please circle	Yes	No		Unclear
Was a care coordinator present?	please circle	Yes	No		Unclear
Date for next ward round included?	please circle	Yes	No		

Frequency of contact with named nurse?	please circle	daily weekly fortnightly monthly other …….	Unclear
Do they have a care co-ordinator?	please circle	Yes No	Unclear
Length of time on CPA/CTP?	please specify	…….years …….months	Unclear

Content of Care Plan

Care plan shows evidence of;				
Inclusion of the person's views	please circle	Yes	No	Unclear
if yes please give at least one example				
Co-production	please circle	Yes	No	Unclear
if yes please give at least one example				
Strengths based assessment	please circle	Yes	No	Unclear
if yes please give at least one example				
Personalisation	please circle	Yes	No	Unclear

if yes please give at least one example	
Personal Budget	please circle Yes No Unclear
if yes please give at least one example	
Recovery oriented practice	please circle Yes No Unclear
if yes please give at least one example	
Person centred goals	please circle Yes No Unclear
if yes please give at least one example	
System based goals	please circle Yes No Unclear
if yes please give at least one example	

The person's views in risk assessment	please circle	Yes	No	Unclear
if yes please give at least one example				
The person's views in risk management plan	please circle	Yes	No	Unclear
if yes please give at least one example				
The person's views in crisis plan	please circle	Yes	No	Unclear
if yes please give at least one example				
The person's views in relapse plan	please circle	Yes	No	Unclear
if yes please give at least one example				
Orientation to social outcomes	please circle	Yes	No	Unclear
if yes please give at least one example				

Orientation to medical outcomes	please circle	Yes	No	Unclear
if yes please give at least one example				
Encouragement for self-management	please circle	Yes	No	Unclear
if yes please give at least one example				
Recognition of personal relationships	please circle	Yes	No	Unclear
if yes please give at least one example				
Advance directives	please circle	Yes	No	Unclear
if yes please give at least one example				

Discharge Planning *if yes please give at least one example*	please circle Yes No Unclear

Notes: please include any other noteworthy information related to the care plan here