

**Care planning for
individuals in
substance misuse services**

**Guidance for using the
Comprehensive Care Plan Form**

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Norfolk Drug & Alcohol Partnership

Guidance for using the Comprehensive Care Plan Form

1.0 What is the comprehensive care plan?

The comprehensive care plan is the culmination of the referral and assessment process. It is the 'map' that states where the client needs to get to and the route for getting there.

The plan follows the initial care plan that will have occurred at the end of the assessment session. The aim of the initial plan however, is to get the work with the client started...and the detail on it holds until the comprehensive care plan is drawn up.

Previous to the introduction of the Norfolk Models of Care comprehensive care plan form – most agencies were either using their agency proforma, or individuals were drawing up their own. Whilst this in many cases was sufficient – care planning nationally has been identified as an area of poor practice. The Norfolk form therefore aims to encourage all workers to work to a similar structure (as stated by the NTA/ Models of Care) in care planning and thus increase the effectiveness of practice.

2.0 When to use a comprehensive care plan

This is used when a client is partaking in structured treatment for substance misuse. Whilst this usually means they will be a client of a tier 3 agency, it is not always the case. Some support/treatment at a tier 2 level can be very structured and gain from using the comprehensive care plan.

Once an assessment has been completed – and treatment is agreed at the assessing agency, the next appointment given will usually be the one that the comprehensive care plan is drawn up in.

If the client for whatever reason is being referred on to another agency following assessment and will be receiving no further input from the assessing agency at this point – the next agency will undertake the comprehensive care plan.

3.0 Key points about a comprehensive care plan

There are several key points to remember:

- client ownership – the form must be completed with the client present – who must agree to what is written down and carry out as many actions on it as they are able
- review – the plan must be reviewed regularly and a new plan started at the end of every review period
- it is a summary document and not supposed to hold all details. Details will be held either in the client's paper file or electronically
- the plan must be SMART!! Specific, Measurable, Agreed, Realistic, Time Limited
- the client must be offered a copy

4.0 Details for care plan use

Date of care plan (top of form)

Enter the date you start the care plan (even if this is over more than one session)

Name of client

Date of birth

Name of GP/Surgery

A surgery name is sufficient. If you are taking this information off the assessment form – check with the client it is still correct.

Keyworker

This is probably you! A keyworker is a worker who is responsible for carrying out a particular modality of treatment with the client – eg named nurse in prescribing service, counsellor.

Care co-ordinator

This may again be you – if your agency is taking overall care for the client. If this is not the case, ask the client if they know who is coordinating their care. If they do not know – and they may not at this point – then liaise with the agencies working with the client to work out who this is.

Agency responsible for the plan

This is the agency that the care coordinator works in.

Phase of treatment journey:

Beginning/middle/end

You are asked to circle one of these. Models of Care asks you to do this so it is clear what stage of treatment the client is in. It may also be a motivational help for the client to see the circle move on future care plans!

Category of need

The care plan is holistic and covers what are known as four domains:

- Substance misuse
- Physical/ psychological health
- Criminal justice
- Social issues.

These have been covered in the assessment and the initial care plan will have indicated where concerns are.

Enter the choice of category in this column.

What is my goal?

Ask the client what their goal is regarding each of their identified categories of need. It must be SMART (Specific, Measurable, Agreed, Realistic, Time Limited!)

What will help me reach my goal?

This means what intervention. For example – if the goal for substance misuse is ‘to inject more safely’ then this box may say ‘use needle exchange’.

Who will do this?

Where possible and realistic, the client should be encouraged to do this. If a worker is doing this – put the name of the worker.

When will this be done by/reviewed?

Write in when you will review the action described. This may be tomorrow – or next week. It must be a maximum of 3 months.

Issues / comments

This is to note any information of concern that might limit the client achieving the indicated goal. This might include dependants, disability, effect of medication that the client is taking.

Signature of client

Ask the client to sign, or initial.

Signature of worker

Sign here yourself.

Date of care plan review

You may be reviewing each category of need often – but you need to do an overall review at 3 months maximum.

Remember to now offer a copy of this to the client.

It is helpful to send a copy to the care coordinator so they know who is doing what.

5.0 Details for care plan review use**Date of review**

Enter the date

Goal 1 – 4

Write a summary of how the work undertaken has gone so far.

What is outstanding now goes into the new care plan.

Signature of client

Sign

Signature of worker

Sign

If you would like this leaflet in large print, audio, Braille, alternative format or in a different language, please contact Norfolk Primary Care Trust on 01603 307266 and they will do their best to help.



This guidance is available to view on-line or download from the Norfolk N-Dap website at: www.nordat.org.uk

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