

Multidisciplinary Care Plan

**St. Catherine's Rehabilitation Unit
St. Finbarr's Hospital**

Name: _____

DOB: _____

MRN: _____

Date of Care Plan: _____

Care Plan review date: _____
(Within six months)

ICD-10 Diagnosis (es):

1. _____

2. _____

3. _____

4. _____

Medical problems:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Part (I):Pre-care plan review meeting with the patient:

Q.1 Currently how do you feel about your mental health ?		
Q.2 What do you think about your current overall care in St. Catherine's Unit?		
Q.3 How can your care be improved?		
Q.4 What would you like to achieve in the next six months?		
Q. 5. How do you think we could help you to achieve these goals?		

Part (II): Needs-based Care Plan:

1. Mental Health

Needs Identified	How to meet these needs	Team Member(s) Involved	6 monthly Progress	6 monthly Progress
Anxiety and Panic Symptoms <input type="checkbox"/>				
Mood-depression <input type="checkbox"/>				
Mood-elation <input type="checkbox"/>				
Psychotic Symptoms <input type="checkbox"/>				
Substance misuse* <input type="checkbox"/>				
Cognitive deficits <input type="checkbox"/>	(MMSEscore) **			

*Include alcohol, street drugs, and over-the-counter medications and prescribed medications abuse

** Record MMSE score in all patients

2. Physical Health

Needs Identified	How to meet these needs	Team Member(s) Involved	6 monthly Progress	6 monthly Progress
Cardiovascular Risk Factors: 1. Hypertension <input type="checkbox"/> 2. Diabetes Mellitus <input type="checkbox"/> 3. Dyslipidaemia <input type="checkbox"/> 4. Renal impairment <input type="checkbox"/> 5. Obesity <input type="checkbox"/> 6. Smoking <input type="checkbox"/> BMIKg/m.m				
Public Health Measures: 1. Flu Vaccine <input type="checkbox"/> 2. Hepatitis status <input type="checkbox"/> 3. Breast check <input type="checkbox"/> 4. Cervical screening <input type="checkbox"/>				
Diet/appetite/nutritional status <input type="checkbox"/>				
Constipation <input type="checkbox"/>				
Other physical health issues <input type="checkbox"/> 1. 2. 3. 4.				

3. Activities of daily living and independent living skills (Tick if impaired)

Needs Identified	How to meet these needs	Team Member(s) Involved	6 monthly Progress	6 monthly Progress
<p>Activities of daily living (ADLs)</p> <p>1. Feeding <input type="checkbox"/></p> <p>2. Bathing <input type="checkbox"/></p> <p>3. Grooming <input type="checkbox"/></p> <p>4. Dressing <input type="checkbox"/></p> <p>5. Bowel control <input type="checkbox"/></p> <p>6. Bladder control <input type="checkbox"/></p> <p>7. Mobility and transfer <input type="checkbox"/></p>				
<p>Independent living skills:</p> <p>1. Money management <input type="checkbox"/></p> <p>2. Medication management <input type="checkbox"/></p> <p>3. Medication on LOA <input type="checkbox"/></p> <p>4. Use of transportation <input type="checkbox"/></p> <p>5. Shopping <input type="checkbox"/></p> <p>6. Cooking <input type="checkbox"/></p> <p>7. Cleaning <input type="checkbox"/></p> <p>8. Healthy and safety skills <input type="checkbox"/></p>				
<p>Impaired social skill:</p> <p>Lack of intimate relationship <input type="checkbox"/></p> <p>Difficulties in communication <input type="checkbox"/></p> <p>Difficulties in sustaining conversation <input type="checkbox"/></p>				

4. Medications (Include both psychotropic medications and physical medications)

Needs Identified	How to meet these needs	Team Member(s) involved	6 monthly Progress	6 monthly Progress
Non adherence to medications <input type="checkbox"/>				
Self-medicating <input type="checkbox"/>				
Previous adverse reactions to medications or interactions <input type="checkbox"/> 1. 2. 3. 4. 5.				
Medications blood monitoring: 1. Lithium <input type="checkbox"/> 2. Clozapine <input type="checkbox"/> 3. Valproate <input type="checkbox"/> 4. Others ----- <input type="checkbox"/>				
Benzodiazepines and other hypnotics On long-term benzodiazepines <input type="checkbox"/>				
Anti-psychotic Polypharmacy <input type="checkbox"/>				

5. Risk:

Risk Identified	Precautions	Team Member(s) Involved	6 monthly Progress	6 monthly Progress
Aggression/violence <input type="checkbox"/>				
Suicide <input type="checkbox"/>				
Non-suicidal DSH <input type="checkbox"/>				
Physical impairment: 1. Falls <input type="checkbox"/> 2. Wandering <input type="checkbox"/> 3. Others ----- <input type="checkbox"/>				
Self neglect <input type="checkbox"/>				
Substance misuse <input type="checkbox"/>				
Exploitation by others <input type="checkbox"/>				
Risk to dependents/other patients <input type="checkbox"/>				
Risk of fire/Arson <input type="checkbox"/>				

6. Rehabilitation:

Needs identified	How to meet these needs	Team member(s) involved	6 monthly Progress	6 monthly Progress
Leisure Activities <input type="checkbox"/>				
Art Therapy <input type="checkbox"/>				
Unit Activities <input type="checkbox"/>				
Workshop / Resource Center <input type="checkbox"/>				
Further Education <input type="checkbox"/>				
L.O.A. <input type="checkbox"/>				
Family Support <input type="checkbox"/>				

Part (111): Summary Care Plan

Care Plan:

- 1.
- 2.
- 3.
- 4.
- 5.

Staff Name: _____

Signature: _____

Date: _____

Staff Name: _____

Signature: _____

Date: _____

Patient's Name: _____

Date: _____

Part (111): Summary Care Plan:

6 monthly progress:

6 monthly progress

Care Plan: 1. 2. 3. 4. 5.	Care Plan: 1. 2. 3. 4. 5.
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Staff Name: _____

Signature: _____

Date: _____

Staff Name: _____

Signature: _____

Date: _____

Patient's Name: _____

Date: _____

Discharge plan :

Plan:

- 1.
- 2.
- 3.
- 4.
- 5.

Staff Name: _____ Signature: _____ Date: _____

Staff Name: _____ Signature: _____ Date: _____

Patient's Name: _____ Date: _____