

Personalised Care Plan (PCP)

What is a Personalised Care Plan (PCP)?

A PCP is a patient centered plan for people with moderate to high complex health needs. It documents

- Problems the patient currently experiences
- What they want to achieve with regard to their health or general well-being, and
- Actions the patient and their care team are going to take to achieve these goals.

The plan aims to support patients to work with care teams to Coordinate care around their needs and priorities and to make the Goals and activities visible to other clinical teams.

Why use a PCP?

- Representation of the patient's voice in their clinical record
- Secure information sharing between care teams in hospital and community care settings

Who can access or contribute?

Any clinical team across the South Island who has access to Health Connect South/Health One.

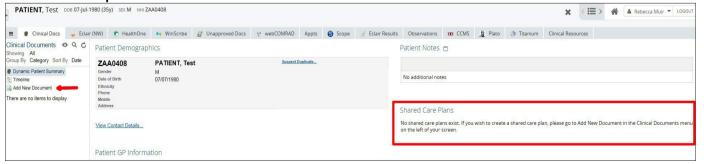
How do you get to it?

Once in the Health Connect South Dynamic Patient Summary follow the links as indicated by the arrows below.

To read or amend a plan



To create a new plan



For further information

For IT and access assistance, contact your IT service desk.

For further information on shared care plans, email; Rebecca.muir@ccn.health.nz

Tips for completing Personalised Care Plan (PCP)

Goals -

The goals determined by the client that are important to them (SMART Goals)

E.g. Be able to read a menu using with hemianopia strategies when out for a meal with friends in one month

- Some goals may remain active for the duration of several services episodes of care, and are appropriate to do so if still relevant to the patients ongoing health needs
- Goals once created cannot be amended by another staff member, they must be Achieved or Cancelled if no longer required/ appropriate
- Individual clinicians can reactive their goals if required
- New goals select a relevant Life Area to put a goal under, then input a individuals SMART goal for the patient (Specific Measurable Attainable Realistic Timerelated)
- Active ongoing goals
- Achieved completed goals that require no further input at this point in time
- Cancelled when a goal is no longer appropria

Actions -

Documents the steps the patient or care team to achieve the patient goals

E.g. Review by Ophthalmologist for vision

Rehab plan – Reading tasks x3 times weekly with Therapy assistant and/or family, review in 6 weeks

Should not be prescribed from one service to another except without prior agreement (exception being CREST, where AH from Chch put in actions for the first two weeks following Chch discharge for support workers to continue working with the patient to achieve these goals)

- Planned items that will completed in the future
- Active in progress
- Completed action concluded
- On Hold not progressing at this point but are likely to reactivated in the near future
- Cancelled when this action is no longer required/ appropriate

If possible, always do the plan with the patient. Their needs and preferences are key to this working well