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

MOUSE, MICKEY DOB 19-May-2006 (16y 0m) GENDER M NHI ZZZ0539

Clinical Docs | Patient Tasks | Meds | Care Plans | Eclair (NW) | HealthOne | Problem List | Appts | Eclair | Cortex | Obs | Southern | Clinical Resources

Clinical Documents
Showing All
Group By Category Sort By Date
Dynamic Patient Summary
Anthropometrics
Add New Document
Clinical Documents (4)
Medications (4)

Patient Demographics
ZZZ0539 MOUSE, MICKEY Suspect Duplicate...
Gender M
Date of Birth 19/05/2006
Ethnicity
Phone
Mobile
Address

Shared Care Plans

Status	Plan Name	Created	Last Modified By	Last Modified
FINAL	Acute Plan	21-May-2019	Rebecca MUIR	02-Dec-2021
FINAL	Personalised Care Plan	05-Apr-2019	Rebecca MUIR	05-Oct-2021

To create a new plan

PATIENT, Test DOB 07-Jul-1980 (35y) SEX M NHI ZAA0408

Clinical Docs | Eclair (NW) | HealthOne | WinScribe | Unapproved Docs | webCOMRAD | Appts | Scope | Eclair Results | Observations | CCMS | Plato | Titanium | Clinical Resources

Clinical Documents
Showing All
Group By Category Sort By Date
Dynamic Patient Summary
Timeline
Add New Document
There are no items to display

Patient Demographics
ZAA0408 PATIENT, Test Suspect Duplicate...
Gender M
Date of Birth 07/07/1980
Ethnicity
Phone
Mobile
Address
View Contact Details...
Patient GP Information

Patient Notes
No additional notes

Shared Care Plans
No shared care plans exist. If you wish to create a shared care plan, please go to Add New Document in the Clinical Documents menu on the left of your screen.

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)	Actions – Documents the steps the patient or care team to achieve the patient goals
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***	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***
• 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 Time-related) • Active – ongoing goals • Achieved – completed goals that require no further input at this point in time • Cancelled – when a goal is no longer appropria	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