

PLANNING CARE

RECOVERY CARE PROGRAMME APPROACH

The Recovery Care Programme Approach – R.C.P.A. – is the process by which an individual’s health and social care needs can be assessed, so that their care and support can be planned, delivered and reviewed by the person, their relatives [carers] and the professionals involved.

The approach consists of four key stages:

[1] ASSESSMENT

During this period all concerns and difficulties should be explored. This can include health and social issues. The person should be seen in context and carers should be included in the process. This should ensure that all the problems identified can begin to be addressed.

[2] RECOVERY CARE PLAN

This should tackle the problems highlighted in the assessment period, what is going to be done to help and who is responsible for making it happen. The person who is unwell must be at the centre of this plan and be agreeable with the proposals. *Carers too, should feel that their concerns and opinions are valued.* It is important that all aspects of the person’s life are considered and that the services needed to enhance this and aid recovery are available. Where services are not available to meet the identified needs a record should be kept so that this may be considered by managers responsible for service development. There must be agreement by all as to the course of action and those responsible for its delivery.

[3] CARE CO-ORDINATOR

This is the named person responsible for co-ordinating the care plan. It should be someone who is able to maintain a good relationship with all parties and to whom concerns can easily be brought should they arise. Clients should be able to change this person without fear of affecting the quality of service offered.

[4] **REVIEW**

The Care Co-ordinator has to make sure that the care plan is reviewed regularly, at least annually, by all involved; identify what is working well, what needs changing, what else needs to be included, so that recovery is ongoing and support can be altered as the individual's needs change.

Carers now have a statutory right to their own assessment of needs, which may be offered during the R.C.P.A. process or at the review stage, or at any time the role has been identified. It may be a difficult thing to do, admitting being a carer, admitting how much it involves, but it should enable you to identify where you can get support to improve how you cope with your role.

PLANNING FOR AN EMERGENCY / CRISIS

Crises happen at all the most inconvenient times – late at night, over a weekend, etc. At such times it is not easy to respond in the best or most appropriate way.

It is helpful, therefore, to try to think about some of the worst-case scenarios in advance, how you might respond, who you might call on and where to keep this information safe and handy. In this way, if things do get difficult, you have some sort of plan set up to help you through.

You will need to know the numbers of out of hours services that are available in your area and have them by the phone or in the phone book. Similarly, you need the numbers for relatives and friends who can be called on at short notice, either to give you support in your home or, if you have to go away, support for those left behind. This is especially vital if it is you that has an accident or crisis rather than the relative or friend with the mental illness.

Contact numbers for all services involved in your relative's care and others who support you should be kept with you at all times. With agreement, they should also be written in to your relative's notes so that they are readily accessible to any persons who might need them.

These plans should be drawn up and agreed by you and the relative / friend you provide care for when that person is calm and

in a stable condition so that everyone is clear about what will happen. This is not always easy; when someone is well you are trying to be positive and not think about the bad times. However, if you can have some contingency plan it may be helpful in actually avoiding a really serious crisis.

This might also be the time to think about drawing up a confidentiality agreement. If you are the person responsible for your relative / friend being sectioned (*see page 36*) or admitted to hospital even voluntarily, you will possibly be the last person that they will wish to be told about what is being done for them. "Patient confidentiality" can sometimes be a convenient screen for professionals to hide behind and not discuss any matters relating to the unwell person. As you are likely to be someone helping with your relative / friend's care when they leave hospital you will obviously wish to be informed about what is happening and how things will be managed in the future and how you will be included in the process. You may need to find some way of encouraging your relative / friend to include you in the discharge planning, helping them to realise that you will be a useful ally in their care.

In order for the agreement to carry weight with professionals you need to ensure that you have discussed it thoroughly with your relative and have had it signed by an independent third party. It will probably be a more acceptable arrangement to your relative / friend if he /she feels that some pieces of information are retained as being confidential, e.g. discussions in therapy groups or individual counselling sessions or seeing their records. In this way they can still keep a certain feeling of thinking for them selves, while allowing you access to information, which they feel, is in their own best interest for you to know. This is beneficial for all parties and ensures that professionals do not breach any of their guidelines.