

RECORD OF PERSONAL PLAN OF CARE REVIEW MEETING

Full name					
Date of last Personal Plan of Care	Date of review	Place of review			
Type of review	Six week		Annual		Other
If other, specify reason:					

The purpose of your Review is:

- To gather your views on the quality of the services provided
- To check whether the support and/or services you receive are achieving what you want them to achieve (i.e. outcomes)
- To check how well the individual needs listed in your Personal Plan of Care have been/are being met, and whether you have any new ones.
- To check if there need be any other changes to your Personal Plan of Care
- If you have a carer(s), to check how they are, and whether they might benefit from a carer's assessment
- To give you an opportunity to say if you would like to get more involved in the way we plan and deliver services

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Patient/client's views on quality of services received (this information will **not** be shared with providers)

The next two pages are a short questionnaire regarding the individual services that you receive. Your view on service quality is **most** important, and this form will be sent to the people in our Department who plan and monitor the quality of services.

Name of Service provider:

How well do you:	Always	Often	Sometimes	Never	No comment	Unable to comment	Comments on the service, including anything you would like to see changed*:
Feel listened to							
Feel valued and respected							
Have support that is flexible and gives you choice							
Have support that is reliable and timely							
Have support that is responsive to changing needs							

Name of Service provider:

How well do you:	Always	Often	Sometimes	Never	No comment	Unable to comment	Comments on the service, including anything you would like to see changed*:
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Feel valued and respected							
Have support that is flexible and gives you choice							
Have support that is reliable and timely							

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Have support that is responsive to changing needs							
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Have support that is responsive to changing needs							
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* A *Concern with Provider* form (page 13) must be completed, if there are serious concerns about the quality and/or practice of individual providers

Review Meeting

Present:

Name	Job title/relationship

Not present:

Name	Job title/relationship	Apologies Yes/No	Written report Yes/No

How well do you consider that the *outcomes* on your Personal Plan of Care have been achieved?

1. Feel safe and secure	Comments:
2. Living where want to, in an environment comfortable to you	Comments
3. Have control over your daily life and routines	Comments:

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4. Have satisfying things to do	Comments:
5. Have good social contacts	Comments:
6. Have your care needs met in an acceptable way	Comments:
7. Stay as healthy as you can	Comments:
8. Have improved health/reduced symptoms	Comments
9. Improve your skills and/or learn new ones	Comments:
10. Be more able to get around your home and community	Comments:
11. Maximise your income and control of your money	Comments:
12. Have your carer(s) supported in their caring role	Comments:
13.	Comments:

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14.	Comments:
15.	Comments

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Needs identified on Personal Plan of Care that have changed in any way, or are not being fully met	Risk level		Comment on how need has changed and/or is not being met	Required changes/actions (e.g. reassessment, minor amendment to Personal Plan of Care, change in provision or provider)
	Then	Now		

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New needs identified	Risk Level	Action code	Specific outcome To be achieved	Describe/quantify how need will be met and by whom	Start Date	Service Delivery (SD) Treatment (T) Manual Handling (MH) plans needed?

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Other aspects of Personal Plan of Care that need to be amended (e.g. contingency plans, key contacts/emergency numbers, provider agencies, NHS Nursing Care and Continuing Health Care eligibility)

Any additional comments and or differences of opinion (e.g between patient/client, carer, service provider, care manager.)

Service Deficiencies

Any previously identified? **Yes / No** If yes provide update on page 14

Any new Service Deficiencies? **Yes / No** If yes complete page 14

Would you like to participate more in the way we plan and deliver services?

Yes / No

If yes, which of the following methods would be acceptable to you:

- Over the phone
 Home visit
 By post
 Meetings (NB We may be able to help with transport)
 E-mail
 All of the above

Do you have a carer?

Yes / No

If yes, has your carer had a recent carer's assessment been completed? **Yes / No**

If no, would your carer like a carer's assessment? **Yes / No**

If No, record reason

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Summary of Review and recommendations

Include comments on strengths and what is working well, as well as what is not

Re-assessment of needs (contact/overview) required?	Yes/No
New updated Personal plan of care required?	Yes/No

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Agreement to your review

If you are in agreement with your Review please sign below

Signature:	Date:
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If the patient/client is unable or unwilling to sign their agreement, please record the reason:

If you do not agree with your Review, please discuss this with your Care Manager/Care Coordinator. If you cannot reach an agreement with them you can request a Review by another worker or you may use the complaints procedures of Powys County Council or Local Health Board.

Consent to Share Information

With your consent, the *summary page* of your Review may be shared with your carer(s), and the people/agencies listed on page 8 of your Personal Plan of Care

If you do not want any of them to receive this information, please list your exclusions below

Name of person/agency not to be given information:

Signature:	Date:
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Review completed by

Name of reviewer:	Job Title/agency
Signature:	Date:

Approved by Manager (Powys Social Services only)

Name:	
Signature:	Date:

Administration

Summary page of Review form <i>given</i> to patient/client by reviewer?	Yes	No
	Date:	
Summary page of Review form <i>sent</i> to patient/client by reviewer?	Yes	No
	Date:	
Summary page of Review form <i>given/sent</i> to all agreed provider(s) by reviewer?	Yes	No
	Date:	

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Service Deficiency form

	Name	Team
Assessor/Reviewer		
Line Manager		

No suitable service available/provided

Outcomes, needs not being met	Comment on any reason for the deficit and suggestion as to the type of service that is required

Service available/provided, but outcome/need not able to be fully met

Current service available, provided	Outcomes, needs not able to be fully met	Comment on why the outcomes/needs are unable to be fully met and suggestion as to how existing service could be improved	
		Quality issue	Quantity issue

SSD Panel/LHB Comm. Team comments/recommendations

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Concern with Provider form

Name of provider agency:	
Source of concern:	Phone number:
Client group:	Type of service:

Brief outline of concern:

Any immediate action taken (e.g. adult protection):

Action agreed at Panel

By Line Manager:
By Shire/Area Manager
By Commissioning/Contracts Team:

Ongoing issues:

Name of assessor/reviewer:	Signature:	Date:
Team Manager authorisation:		

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