Protocol 2

Comprehensive assessment & developing an Interagency Care Plan

Outcomes

A. Completion of a comprehensive assessment addressing the wider needs of the service user.

B. Development of an interagency care plan with all areas of identified need addressed and actions/interventions agreed between the service user and all service providers.

C. The Case Manager in the lead agency is identified along with the key worker/point of contact in each service responsible for progressing each action and an agreed time-line.

D. The interagency care plan is regularly reviewed and updated reflecting the current needs of the service user.

Key Processes

1. As the service user continues to engage with services following initial assessment, a comprehensive assessment should be undertaken as part of the process to developing an interagency care plan. An interagency care plan involves the service user and all existing and future services involved in their care, contributing its development.
2. The interagency care plan will outline the interventions agreed, referrals required and timeframe outlined to review the intervention/issue/action identified.
3. If a comprehensive assessment has already been completed by another service, there may be some value in obtaining a copy which may be updated with the service user.
4. The key worker should explain and obtain the service user's written agreement to share relevant information that the service user has provided in the comprehensive assessment for purposes of referral or making contact with other services for additional supports.
5. The comprehensive assessment should be carried out by a trained and competent person. Training levels and competencies to be agreed by NDRIC.
6. The comprehensive assessment should be completed in line with the common assessment guidelines and a care plan developed with realistic goals and addressing the physical, psychological, social and legal needs identified.

7. An essential part of developing the interagency care plan is the involvement of services already working with the service user and with any new services identified to agree actions and timescales.
8. Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or the Interagency Care Plan Meeting Protocol.
9. Criteria for determining the most appropriate lead agency, should include :
    a. Intensity and regularity of contact with service user
    b. Capacity of service provider
    c. Client preference
10. The case manager is generally appointed from within the lead agency, but both positions may change over time, by agreement at the interagency care plan meetings, as progress of the interagency care plan goals is achieved.
11. The case manager assigned to the service user will manage and co-ordinate the implementation of the interagency care plan agreed among the services identified in the interagency care plan.
12. The case manager is responsible for monitoring and following up on referrals and general goals and responding to issues or blocks as these arise.
13. The case manager is responsible for ensuring the interagency care plan is reviewed with the service user at agreed intervals and updated as required.