COMITE EUROPEEN POUR LE DEVELOPPEMENT DE L'INTEGRATION SOCIALE

Personalised Care Plan Development Guide

GEPAP

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Personalised Care Plan Development Guide

Methodological guide

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Main principles underlying the Personalised Care plan

Foreword

This updated version of the Personalised Care Plan (PCP) development guide was drawn up in the context of the Leonardo da Vinci Multilateral Projects "Transfer of Innovation" programme. The following organisations and their partners took part in this project: CEDIS (European Committee for the Development of Social Integration – initiated the project and created the first draft of this guide) from France, Altea España from Spain, Questao de Equilibrio from Portugal, Siksali Development Center from Estonia, SOS Children Village from Latvia and Les EPI de Genève (Public Institutions for Integration) from Switzerland. Following the research and experimentation carried out by the different teams of social workers, the initial methodology has been improved.

This Personalised Care Plan development guide (PCPDG) aims to provide guidance to anyone desiring to structure in a personalised and dynamic fashion the care they offer to service users in their ward or institution.

The PCP methodology is particularly useful to social and medico-social workers, but also to service users themselves, their families and volunteers involved.

The PCP is a methodology to plan and coordinate care services in a way that is dynamic, flexible and adapted to each service user, regardless of their vulnerability, needs, or specific circumstances.

The PCP's approach is to empower service users. It gives them a sense of responsibility – making them more independent – and the status of partner, on equal terms with workers and relatives.

The PCP and its implementation within social and medico-social services and institutions can be a way to comply with the laws and regulations in force, demanding that each service user be given a prevalent role in deciding the conditions of the care they receive.

Approach and definition of the PCP

Approach

- The PCP's approach is above all to coordinate the actions of those who work together to
  - help someone experiencing a problem of adaptation,
  - meet their needs,
  - enable them to be a fully integrated and active member of their community, whilst taking their desires and potential into account.

- The PCP's approach is also a process that allows:
  - the identification of someone's capacities and needs,
  - the determination of suitable development and learning objectives,
  - the implementation of resources to meet their priority needs.

- The PCP's approach is to directly involve the service user and their relatives, as well as the social and medico-social workers most significant to them.

- The PCP's approach is a tool to coordinate the services and resources allocated to service users.

- The PCP's approach is to give a sense of responsibility to all those involved in the process: the service user, their relatives, their legal representative when applicable and the social and medico-social workers that have been identified as being particularly significant to the service user.

Definition

The PCP is a planning and coordination tool designed to help organise services and resources so as to meet the long term needs of a person.

It is an ongoing process, regularly reassessed and updated.

This process aims to associate all those involved – the service user, their relatives and social and medico-social workers – as equal partners.

It is an action plan compiling all the interventions into a coherent plan centred on the service user.

A different plan implemented by a different team is therefore devised for every single service user.

The PCP is built upon the service user's characteristics and needs. It identifies the services to be supplied as well as the resources needed, coordinates the interventions detailing who, when and how these services need to be supplied and assesses their efficiency in light of the stated integration objectives.

The PCP ensures that the service user and their family take part in the designing of the plan as full members of the PCP team.

The PCP's essential components

The following fundamental components must feature in each PCP:

1. The **recognition of the rights and liberties** of those who, because of their age, mental or physical condition or social situation, are denied them,
2. The **respect of the principles of Social Empowerment** that can be summarised as follows :
   - Giving each person, however different they are, the capacity to live in their normal environment or in an environment as close to it as possible.
   - Strongly encouraging social interactions with other members of the community.
   - Encouraging an optimum participation of every service user in their ordinary and habitual activities (studies, work, leisure, consumership, decision-making, etc.).
   - Use resources as rewarding and usual as possible, in the context of interventions and interpersonal relations.
   - Creating a life environment (income, accommodation, access to services…) as consistent as possible with their personal social background.
   - Appreciating with tolerance each service user's behaviour, experience and status.

Via an ongoing activity directed both towards the service user and their social environment, Social Empowerment aims to:

- develop the service user's capacities and know-how or competences, utilizing, to do so, suitable learning techniques and equipment,
- improve the service user's social image, which implies that they can participate in rewarding social roles and access anything that could improve their social image, whilst meeting their individual needs.

3. The **service user's full participation** as an equal member of the PCP team.

   If the service user cannot fully participate in the team meetings, they should at least be able to attend them accompanied by a tutor or any other representative of their choosing.

4. **A transdisciplinary team** in charge of the conception, implementation, monitoring and assessment of the plan.

5. A **general and relevant assessment** of the service user's capacities permitting the identification of their desires and needs.

6. **Realistic long-term goals** based on a series of feasible short and mid-term operational objectives detailed in a clear and positive manner.

7. A detailed **allocation of responsibilities** to each team member in terms intelligible to all (who does what, with whom, when, where and how).

8. A **documentation** measuring the progress being made towards reaching goals and objectives, using *ad hoc* existing or to-be-created assessment tools.

9. A **system** to measure the progress of the plan and to revise it if necessary.

The PCP's team

The service user's position

Any person placed in the care of a social institution or social workers should retain the ability to exercise their individual rights and freedom. They should therefore be guaranteed the following:

- The respect of their dignity, integrity, privacy, intimacy and safety;
- The ability to freely choose from the different relevant services available to them, either at their home or in an institution, taking into account the powers recognised to the legal system as well as the need to protect minors;
- **An individualised care plan adapted to their age and needs, encouraging their development, autonomy and social integration; every effort must be made to seek a qualified acceptance of the plan from the service user, when they are able to express their wish and participate in the decision-making, or from their legal representative otherwise;**
- The confidentiality of their personal information;
- Access to any information or documentation related to their care plan, unless a legal restriction is in place;
- Information about their fundamental rights and the specific legal and contractual protections they are entitled to, as well as the legal appeals available to them;
- **A involvement either direct or with their legal representative's help in the creation and the implementation of their personalised personal care plan.**

It is therefore crucial **to respect the person's free will and allow them, taking into consideration their capabilities and aspirations, to remain master of their own destiny, and to offer them a personalised care plan based on a written contract. This plan will need to contain the objectives agreed upon with the person, as well as the means that will need to be used to achieve these objectives.**

The PCP considers that the service user must remain leader of their own life plan.

In consequence, the service user is, either on their own or accompanied by a person chosen by them to assist or represent them, a permanent and full member of the PCP team.

Therefore, it is imperative to:

- respect the service user's rights,
- build on the service user's capacities,
- take into account the service user's tastes, interests, abilities and point of view,
- encourage the service user to participate by giving them all the information necessary to take the decisions that concern them,
- explain every step of the PCP process to the service user and accompany them through it,
- adapt objectives to his strengths and needs
- give the service user a sense of responsibility regarding the objectives to achieve

Note:

For some service users the issue of their family's participation presents itself differently.

In many cases their participation will increase the plan's chances of success. However it must be admitted that sometimes the family's interests and the service user's simply do not coincide.

It also sometimes happens that some families and even in some instances, workers, do not act in the service user's best interest. In that case, it is important to refocus the team's activity on the service user's best interest.

Transdisciplinary methodology

In many wards and institutions the team organisation that prevails is still based on interdisciplinarity only. This provokes a juxtaposition of workers of various disciplines who make different types of analysis that generate plans often independent from each other. Even though these plans all aim at globally helping the service user's development, they often introduce a lack of coordination in the service user's individual project.

To enable a team to work in a genuinely transdisciplinary way, some principles must be respected:

- every member participates in the decision-making,
- every decision is made as a team,
- the service user is a full and equal member of this team,
- the PCP is conceived by all the members together,
- members interact together,
- the project coordinator facilitates communication between members.

The basic principles of work in a transdisciplinary team are:

- **cooperation;**
- equality of rights;
- consensual decision-making.

♦ Cooperation

The team members' qualifications, competences and experience differ. All of them, individually and together, must focus on the service user's strengths and needs to avoid antagonistic actions and have for their only concern the service user's general development. Everyone must therefore make an effort to preserve a team spirit.

♦ Equality of rights;

In a transdisciplinary team, every member of the team puts their expertise at the service of the others. There is no place for any rivalry or any dominance of some disciplines over others.

There is therefore an equal authority that allows everyone to express themselves freely on every aspect of the programme, even when they retain a more particular interest in their domain of competence.

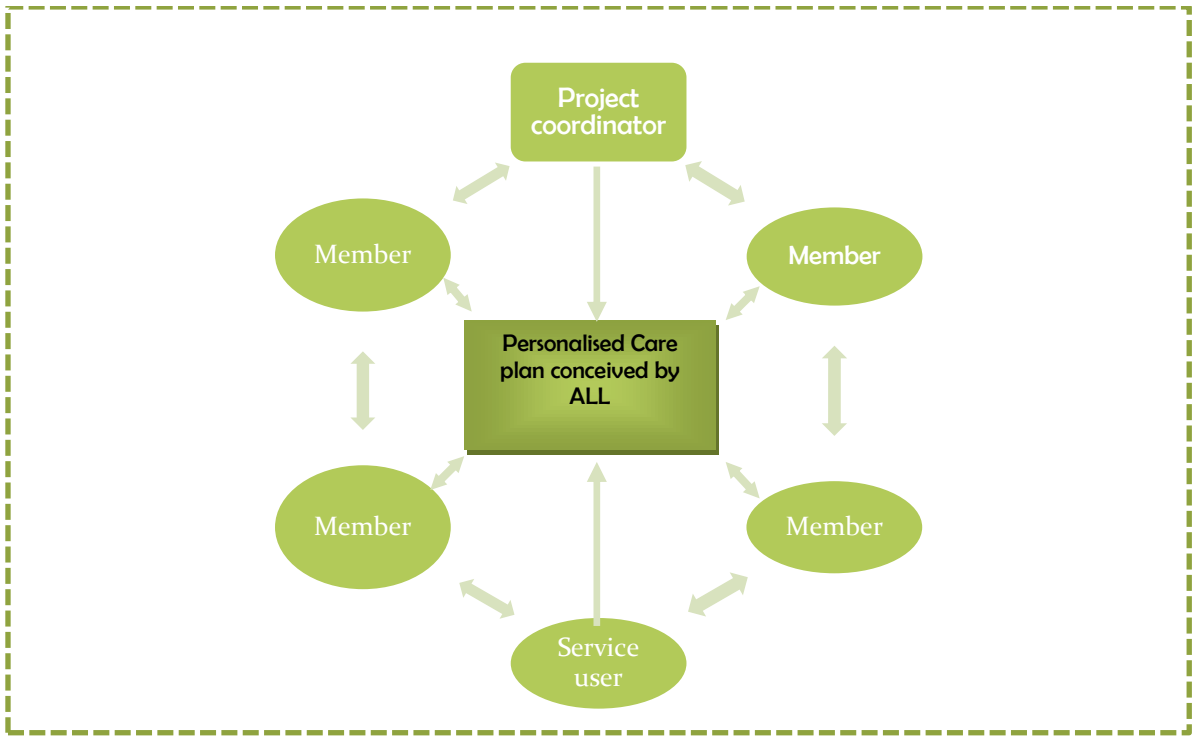
♦ Consensual decision-making

In a transdisciplinary team there is no right of veto since there is equality of rights. The team makes the decisions.

This allows for a greater involvement of all the members.

In a team working in such a way, the decision-making process can take more time and energy, but it allows for a greater cohesion.

Only the team can decide, by consensus and depending on their global vision of the service user's needs and on the prioritisation of interventions, to accept a suggestion, uphold a decision, recommend a service or reject a suggestion.



How a transdisciplinary team works

The service user's common interest and the indispensable spirit of cooperation expected from equal partners must transcend the different professional disciplines in play.

Formation of the PCP's team

The team in charge of implementing a service user's PCP is at the heart of the process.

Each team is formed depending on the service user's needs. It usually comprises between four and six members including the project coordinator, the service user, their referring doctor, significant contributors and/or persons considered as "close" (relatives, partners, friends, etc.).

Ideally, the members of the team are chosen or accepted by the service user themselves. If they are not able to make this choice alone, it must neverthless be approved by them, their representative or their relatives. Each one of the team members must pledge to fulfil their position in accordance with the service user's wishes. The team and each one of its members must ensure the quality, relevance and dynamism of the process undertaken.

♦ The significant contributor

The significant contributor is any person who has created a significant personal bond with the service user. This person can be a social or community worker, a family member or a friend.

Whoever this person is, they must be willing and able to play an active role in the service user's life and make some specific contribution towards meeting their needs. They must also respect the service user's rights.

♦ The project coordinator

The project coordinator is in charge of the PCP's planning and implementation on behalf of the service user. The project coordinator is there to support the service user but the service user and/or their representative remains in charge of the general process.

The project coordinator's task is demanding and there are many varied competences and skills needed:

- Firstly, the project coordinator must subscribe to the values upon which the process is based.
- The project coordinator must possess a theoretical as well as practical knowledge of the PCP.
- The project coordinator must possess organisational and leadership skills.
- The project coordinator must be responsible and autonomous**.**
- The project coordinator must be able to listen, articulate, summarise and have excellent interpersonal skills.

- Finally, the project coordinator must have all the skills required to bring the service user and the other members of the team together to work in a transdisciplinary way.

The position of project coordinator is a proper job that requires training like any other profession. The project coordinator's role is central to the implementation and the running of the PCP, which implies a reorganisation of human resources in the ward or institution where it is implemented.

It is sometimes assumed that, upon the service user's request, the most significant contributor can be named project coordinator, or even that the service user themselves can hold this role. We do not share this view. Because of the complexity, multiplicity and variety of the tasks to perform, it is not possible for a contributor to simultaneously hold their own role (psychologist, physiotherapist, youth or social worker, etc.) and that of project coordinator.

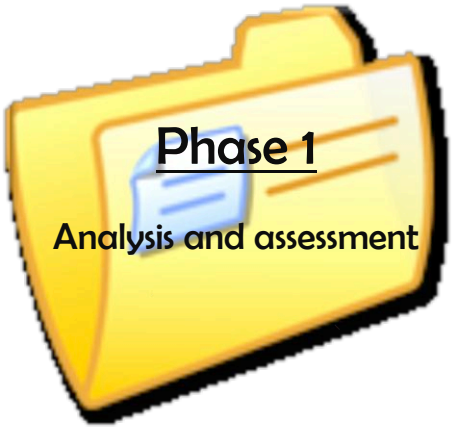
In terms of hierarchy, the project coordinator does not yield any particular authority within the transdisciplinary team. They are there to ensure that the PCP process runs smoothly in accordance with the service user's wishes and that everything is done to meet the service user's needs.

Although the project coordinator is not involved in every single aspect of the process, their tasks (see below) are essential:

- Obtain and gather information about the service user.
- Help the service user to assess their life, identify and anticipate their needs and express their desires regarding how the PCP team is formed,
- Schedule and prepare the various PCP meetings,
- Chair the PCP meetings,
- Draw up the contractual agreement and send it to the relevant parties,
- See that the PCP is implemented,
- Coordinate the interventions,
- Activate internal and external resources,
- See that the planning is observed,
- Put in place assessment processes.

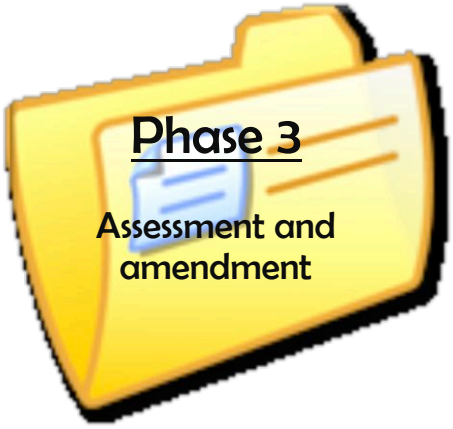
The PCP's development procedures

The Three Main Phases of the PCP



- Collecting of information
- Identification of desires, capacities and needs
- Prioritisation of needs

- Articulation of operational goals and objectives (Short, mid- and long-term)
- Development of a plan
- Allocation of responsibilities
- Implementation of the plan



- Assessment of the adequacy of the actions undertaken with regards to the initial goals
- Assessment of the results obtained
- Implementation of amendments necessary to the continuation of the project

Information and assessment

Information must be gathered in order to thoroughly know and understand the service user, their present situation and their personal history. This investigation consists of obtaining information about the service user from themselves, their relatives, workers and anybody else somehow related to them.

This information will include observation forms and reports, accounts of interviews with various medical and medico-social parties and evaluation reports about health, psychological, social and educational issues.

The information gathered must cover the essential elements of the service user's life : physical and mental health, education, training, identity, social background, family and social relations, social skills, emotional life and behaviour and autonomy.

It is a tool to know and understand the service user in the relational, social, affective, sensory motor, cognitive, autonomy and communication fields.

All this information together will then make it possible to make as thorough as possible an assessment of the service user's characteristics : their skills, abilities, achievements, tastes and desires, relationships, the resources they use, their attitudes and behavioural patterns, deficiencies and difficulties, material and legal situation, etc.

This assessment, which is and remains property of the service user and/or their relatives, is an essential tool for the PCP team but also for the service user themselves and/or their relatives, and it is important to help them understand it and make it their own. This assessment must enable the service user, along with their relatives, to identify their own abilities and needs.

During the investigation phase, it is crucial that the service user's intimacy and privacy be respected by all.

In addition, their agreement, or that of their representative, is necessary and indispensable for any information sharing about the service user.

General identification of desires, abilities and needs

The practical implementation of a PCP is based on the general identification and assessment of the service user's desires, abilities and needs emerging from the assessment previously described.

While it is still common practice in the social and medico-social sector for interventions to be decided on according to a person's deficiencies, the PCP on the contrary leads its users to develop an approach based on a person's abilities, so as to meet their needs, complement their deficiencies and improve their general situation. These abilities can be the service user's but they can also be part of their social environment, and all these elements must be taken into account.

Those in difficulty, either because of illness, deficiencies, age or marginalisation, have the same needs as anyone else, but the way to meet these needs must be adapted to their situation. Therefore, in the context of the PCP, a person's needs must be defined according to a human being's fundamental needs but also according to the specifics of each situation. **Priority must be given to the identification of the needs, before considering resources and strategies to meet them. The services that an institution or ward can provide must be adapted to the realities and needs of each one of the service users, and not the other way around**.

Identification of resources

To identify a service user's abilities and resources is to establish their positive personal assessment by looking at them differently, with their interests and those of their relatives in mind, helping them to view themselves through their aspirations rather than through their difficulties and needs. This is meant to make service users feel valued. In that spirit, every topic can be covered with them in order to help them build their life.

A list of potential questions useful to draw up the positive personal assessment includes:

- What is it like for the service user when everything is fine?
- What do they really like doing?
- What can they do?
- What are their specific competences?
- What have they achieved?
- How do they positively respond to events or people?

- How do they communicate with people around them?
- Do they have any family, partner, friends ?
- Do they own anything ?
- Are they attached to what they own?
- Etc.

To build the list of a service user's abilities is to make an inventory of their positive characteristics and to classify them in the relevant developmental spheres (family, school, work, leisure, social groups, etc.)

Identification of needs

A need is defined as the gap between a desired situation and the actual situation.

To identify a service user's needs is to define what they can still achieve or what can be supplied to them to optimise their potential and thus generate a more rewarding personal, familial and social situation.

A need can be met by the acquisition of knowledge, attitudes and know-how and by the use of internal or external resources of the institution or ward. The need is met when the desired situation materialises.

To ensure that a service user's fundamental needs are met and to give these needs the right level of importance, we have chosen to use Maslow's "Hierarchy of needs".

He presents to us a hierarchy of human needs represented as a pyramid at the bottom of which are primary physiological needs and at the top self-fulfilment needs.

To make the pyramid on page 26 more explicit, the different levels are described hereafter.

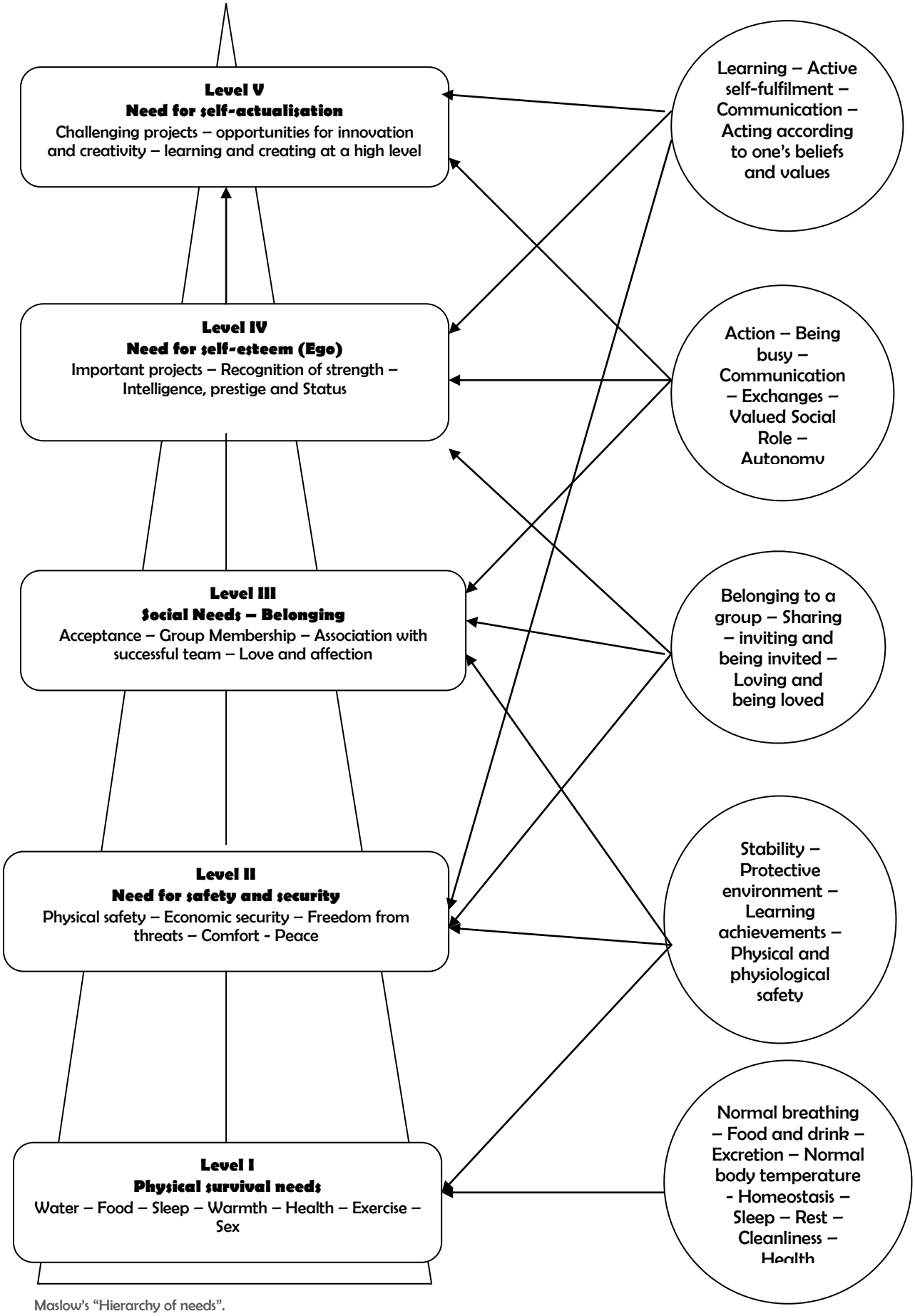
Physiological needs: breathing, food, water, sex, sleep, homeostasis, excretion.

Safety needs: to feel reasonably safe from present and future threats and dangers, to live without fear in a protected, safe, ordered, structured, stable and predictable environment (as opposed to threatening, anarchic and unsafe). To be physically and physiologically safe.

Love and belonging needs: to communicate, act, give and receive affection, friendship, love, have intimate relationships and be part of communities such as a club, a team, a group of work colleagues, a clan, a tribe; not to be alone, isolated, rejected or forgotten.

Esteem and consideration needs: self-esteem (the need to love oneself, to be proud of what one is and of one's achievements; to feel competent, independent of others, to be able to succeed in what one does) and esteem by others (the need to be respected and admired, to have a certain prestige, a good reputation, a recognised and valued social status, the need to be encouraged, rewarded, appreciated and recognised).

Self-actualisation and spiritual needs: to use all one's potential and one's talents, to become what one is capable of being, to leverage all the aspects of one's personality (intelligence, imagination, aptitudes and various other skills); exploit and develop one's physical and other capacities (to grow and improve in all possible ways); to launch projects and implement them, to have a philosophy or a belief that enables one to give meaning to things, events and eventually, life.



Maslow's "Hierarchy of needs".

Prioritisation of needs and articulation of objectives

Once the needs have been identified, they need to be sorted by level of importance and then the goals and objectives that will help to meet them can be articulated. Ultimately it is the service user who prioritises their needs, helped by the other members of the team.

Prioritisation of needs

To prioritise needs is to sort them by level of importance. To do so, it is necessary to:

- Consider whether the fundamental needs are met (primary physiological needs);
- Consider whether there are needs to be met in each developmental sphere (safety and confidence needs, love and belonging needs, esteem and consideration needs, self-actualisation needs);
- Respect a certain hierarchy of needs that takes into account the service user's experience and life circumstances;
- Measure the effect of choosing to satisfy one need rather than another;
- Compare the needs that have been articulated by different sources when information was being gathered;
- Check that there is a satisfactory level of consensus within the team regarding what needs must be met;
- Only select two or three needs to satisfy, but other needs must not be ignored.

Articulation of goals and operational objectives

After having identified and prioritised the needs, the PCP team outlines the operational goals and objectives whose fulfilment will satisfy the service user's needs in order of priority. Throughout this process, the service user's interest must remain central.

The goals are closely linked to the service user's priority needs and indicate the general direction given to the PCP. They broadly describe the evolution the institution or ward aims to encourage in the service user, according to their acquisition needs and strengths (in a long term perspective).

The operational objectives can only be decided after the goals have been outlined. They describe the type of interventions to be implemented in order to fulfil the goals. They are the stages to go through to fulfil the goals.

The number of goals and operational objectives must be limited in order to ensure efficiency. After having defined these goals and objectives in accordance with the service user's potential, **strategies to leverage resources** have to be defined.

This means identifying all potential or existing obstacles, putting in place adapted solutions and mobilising the technical and human resources needed.

Allocation of responsibilities and planning

- After having identified the service user's abilities and needs and prioritised their needs;
- After having defined goals and operational objectives;

it is time to allocate responsibilities and set a timeframe.

Allocation of responsibilities

This is about deciding who will do what, with whom, when, where and how.

This stage consists in allocating between the members of the transdisciplinary team, the responsibilities related to the goals and operational objectives to fulfil.

Each member will then have to define the strategies to implement and identify the necessary technical and human resources, either internal or external.

Planning

The goals and operational objectives are to be fulfilled progressively within a certain timeframe, which means that the planning stage is essential and has to be extremely rigorous.

Depending on the service user's evolution and characteristics, an anticipated revision or modification of the process can be decided on by the transdisciplinary team.

The PCP meeting

Preparation for meeting

The project coordinator is in charge of preparing the meeting.

- The project coordinator gathers all the observation reports and assessments carried out in the different sectors where the service user lives. (Social investigation, health, psychological and psychiatric examinations, behaviour reports, school reports, work reports, leisure observation reports, etc.)
- With the service user's and/or his representative's prior approval, the project coordinator individually contacts each significant person able to contribute any information about the service user's situation.
- Based on the elements thus collected, the project coordinator draws up a table of the service user's abilities and needs which is then distributed to each one of the members during the meeting.
- The project coordinator must make sure that the service user is happy about the selection of participants to the meeting.
- In collaboration with the service user and/or their representative, the project coordinator draws up an agenda which is then shared with every participant. The invitation to the meeting must feature the meeting location, date and time.

The meeting

The project coordinator chairs the meeting.

The project coordinator ensures that the meeting environment allows the service user and the other PCP members to express themselves freely.

The project coordinator encourages everyone to express themselves and if necessary re-articulates in simple and intelligible terms what was said.

The project coordinator makes every effort to reach a consensus.

It is indispensable that one of the members of the team should take notes so as to facilitate the drawing up of the written contract that the service user and the other participants will sign.

When the agenda of the meeting has been introduced, potentially amended and finally approved, the list of the **service user's abilities and needs is presented** and if necessary complemented.

Following this presentation, the service user and/or their representative determines what the priorities are, in other words what is most important and interesting to them. If necessary, the team determines by consensus which needs are a priority, depending on the service user's interests, aptitudes and social circumstances.

Once the priority needs have then been identified and the operational objectives planned, responsibilities can be allocated.

The strategies and resources necessary to achieve every objective are not necessarily determined in the course of this meeting. They can be determined later by those responsible for each objective.

After the meeting

After the meeting, the project coordinator writes the report which then serves as a "contract" and is distributed to all the participants.

Now that the project has been defined, it is time to implement it and organise a regular assessment of it in order to make necessary adjustments.

The project coordinator monitors on a regular basis the progress of the process, collects information, plans and chairs the meetings.

At every milestone defined in the timeframe, a meeting takes place to assess the results obtained and if necessary amend the goals and operational objectives. If it is impossible for all members to be present, these meetings can take place in the presence of the service user and/or their representative, the project coordinator and the workers directly concerned by the subject of the meeting.

At the end of the process, everything is assessed and updated with all the PCP members.

Example of a follow-up schedule

After a maximum of 1 month the project coordinator checks with the service user that the PCP is truly in place and functioning.

Every three months a meeting takes place to assess the results obtained and revise the goals and operational objectives.

After a year, the entirety of the process is reassessed and revised by the entire PCP team.

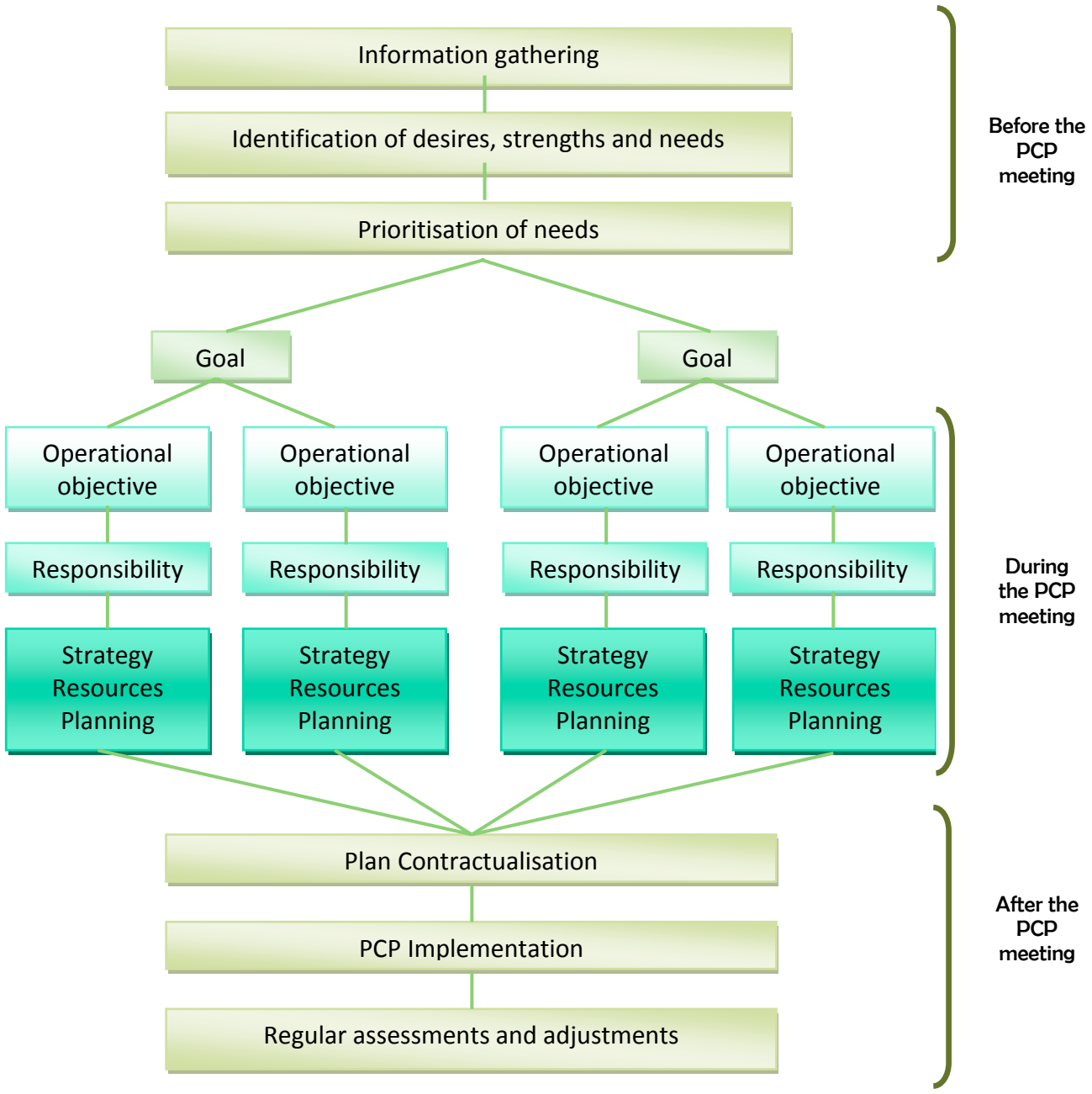
The written contract

The different elements that make up the PCP and that must feature on the contract, binding the workers and committing them to act together, must be written in a clear and intelligible manner and must be distributed to all the members of the team.

It must include:

- The contact details of the service user, their family and their relatives;
- A general description of the situation;
- A description of the service user, their capacities and their needs;
- A description of the goals, operational objectives and responsibilities;
- A description of the internal and external resources to be used to fulfil the operational objectives and goals;
- A general description of the strategies and resources used;
- The assessment and regulation criteria used;
- A timeframe.

The PCP's process



The PCP's process

Synthesis

To ensure that all the elements that need to be taken into consideration for the creation and implementation of the PCP have indeed been taken into account, it is crucial that the project coordinator and their team partners ask themselves a number of questions including the following.

1. Is the service user at the centre of the process?
2. Has the service user been consulted when information was collected about him/herself?
3. Have his/her intimacy and right to privacy been respected?
4. Has the service user agreed to share information about him/herself?
5. Has the service user been consulted on his/her tastes and personal interests and has he/she been able to express their preferences?
6. Has the service user fully participated in the assessment of the preparation, running and follow-up of the PCP meeting?
7. Is the service user able to concretely explain the importance of the PCP in his/her life?
8. When the service user is not able to actively participate, is their representative consulted and involved in the process?
9. Have all significant contributors been involved in the process?
10. Have the service user's strengths, resources and needs been fully detailed in order to know the service user?
11. Have all members felt involved in the process and have they actively participated?
12. Are the goals and operational objectives clear and realistic? Have they been prioritised and achieved? Are they likely to represent a concrete and tangible improvement for the service user?
13. Do team members carry out their responsibilities both individually and collectively according to what was decided?
14. Has the project coordinator involved all the partners in the process? Has he/she clearly and precisely explained the next steps?
15. Has the next meeting been scheduled?

Important Reminders

- REMEMBER that the PCP is a process that gives a direction to a person's life but it is not an end in itself. It is a means.
- GIVE PRIORITY to the active participation of the service user, as he/she is at the heart of the process. The PCP meeting is a meeting about a person and their needs. It is not a case study between experts.
- DRAW UP A PCP based on a positive interpretation of the concepts of strengths and needs. Often what seems to be a difficulty is actually a need for the person.
- DISPENSE WITH endless conversations over resources, plans and methods during the meeting. These are the responsibilities of the worker in charge of each operational objective. This worker is also in charge of determining the adequate strategy and resources.
- MAKE ALL THE NECESSARY EFFORTS TO REMAIN informed, properly trained and self-reassessing.

IT IS ESSENTIAL TO ENSURE THAT THE SERVICE USER

IS THE MAIN CONTRIBUTOR TO THEIR PROJECT

Technical Forms

Each team will need to create their own working tools depending on context and needs.
The following forms are only given as examples.

List of technical forms

Name of the person :

I- IDENTITY AND ADMINISTRATIVE SITUATION

First name:..... **Last name**:.....

Born on / / **in** .....

Sex : Male ❑ Female ❑

Marital status:

Single ❑ Married ❑ Separated ❑ Divorced ❑ In a partnership ❑

Contact details:

Address:.....
.....

Phone number:..... E-mail .....@.....
Mobile: .....

Name of parents or guardians:.....
Address:.....
.....

Phone number:..... E-mail .....@.....
Mobile: .....

Persons to contact:

Full name:.....
Address:.....
.....

Phone number:..... E-mail .....@.....

Full name:.....
Address:.....
.....

Telephone : ..... E-mail .....@.....

Placement upon request from:

Service user ❑ Social services ❑ Health authority ❑ Other ❑
Legal authority ❑ Family ❑ Administrative authority ❑

Date of admission : / /

Contact worker: .....

Name of the person :

2- FAMILY SITUATION AND NETWORKS

Family: Persons living in the same household

	First name	Last name	Age
Father			
Mother			
Partner			
Partner			

Children living in the same household:

First name	Last name	Age

Children not living in the household:

First name	Last name	Age	Place of residency

Other persons living in the household:

First name	Last name	Age	Relation

Name of the person :

Material situation:

Accommodation

Job situation

Income

Family history:

✎ *Describe here the main elements of the service user's family history necessary to know the user better.*

Name of the person :

Networks:

✎ *List here the persons who appear significant to the service user.*

	First name	*Last name*	*Regularity of contacts*	*Address*	*Phone number*
Family members					
Extended family					
Friends					
Neighbours					
Other persons					

Name of the person :

3- SCHOOL AND/OR PROFESSIONAL EDUCATION

School education

Establishments attended:

Positive experience:

Situations of failure:

Persons who stood out:

Qualifications obtained:

Professional training

Course attended:

Internships:

Positive experience:

Situations of failure:

Persons who stood out:

Name of the person :

4- JOB HISTORY AND INCOME

Job history:

Positions held:
Positive experience:
Situations of failure:
Persons who stood out:

Current job: _____

Type of contract : Permanent ❑ Temporary ❑ Apprenticeship ❑
Other ❑ (*detail*)_____

Financial income:

Salary ❑ Work benefit ❑ Housing benefit ❑ Family/child/social benefit ❑

Others ❑ (*detail)*_____

Protection measures:

Guardianship yes ❑ no ❑
Curatorship yes ❑ no ❑
Other (*detail)*_____ yes ❑ no ❑

Name of the person :

5- PHYSICAL AND MENTAL HEALTH

Administrative information:

National Insurance Number or equivalent:

Treating GP: ……

Address:.....

.....

Phone number: .....

Last check-up on: / /

Medical information:

Surgical operations

Physical health issues

Mental health issues

Name of the person :

Allergies

Current treatment(s)

Medical and paramedical information

	Name of practitionner	Contact details
Orthophonist		
Ophtalmologist		
Dermatologist		
Physiotherapist		
Ocupational therapist		
Gynecologist		
Dentist		
Psychologist		
Psychiatrist		

Name of the person :

6- CULTURAL AND LEISURE ACTIVITIES

Activity	Contact person	Contact details	Length ofpractice	Frequency of practice	Level

Name of the person :

7- SOCIAL INTERACTIONS

Relations with other service users in the ward or institution

Relations with other people outside the ward or institution

Relations with workers of the ward or institution

Relations with family members and relatives

Name of the person :

8- STRENGTHS AND SKILLS OF THE SERVICE USER

✎ *Write down all the strengths and skills people around the service user think he/she possesses.*

Skills – Strengths	Sources of information

Name of the person :

9- DIFFICULTIES AND CHALLENGES FOR THE SERVICE USER

✎ *Write down the difficulties felt by the service user in various development spheres (family, school, work, leisure, socialising...) and representing for him/her challenges.*

Difficulties-Challenges	Sources of information

Name of the person :

10- NEEDS AND EXPECTATIONS OF THE SERVICE USER RESOURCE PERSONS AND USEFUL STRUCTURES

✎ *Write down the service user's various needs in terms of resources or services as well as plans and interventions.*
List the various people and services that could be of moral or material assistance to the person in care.

Needs are not resources !

Exemple Example : Peter has difficulty producing speech. His need is to speak properly. The resource used to achieve this is speech therapy.

Development spheres	Person's expectations	Needs	Resource persons or services	Skills	Contacts
Accommodation					
Physical and mental health					
Professional and school integration					
Transport					
Social life					
Other					

Name of the person :

11- FORMATION OF THE PCP TEAM

First name	Last name	Address	Phone number	Title	Role

Name of the person :

12- SELECTION AND PRIORITISATION OF SPECIFIC NEEDS

Need	Level of importance

Name of the person :

13- PCP PLANNING

Prioritised needs	Goals	Resources and strategies	Persons in charge	Deadline

Full name of the service user:	**MEETING REPORT** **Object:**	**Meeting on:** **/ /** From … h to … h Location:

Attended:	**Missed:**

Report by:

On: / /

Number of Pages**:**

Report

Decisions

Next Meeting: Object: Date: Time: Location:	**Invited:**	**Distribution:**

Bibliography

Daniel BOISVERT	Le plan de Service Individualisé Université Québec
Richard COTE et Wilfried PILON	Guide d'élaboration des plans de service et d'intervention – GREED Québec
Alain DUPONT, Jacques PELLETIER et Jean-Philippe NICOLETTI	PRP Edition des deux continents GENEVE
Jacques PELLETIER	Le plan de service Individualisé, outil d'intégration et valorisation Edition des Deux Continents GENEVE
Nicole MONTREUIL et Ghislain MAJEROTTE	Pratique de l'Intervention Individualisé de BOECK Université Bruxelles
Wolf WOLFENSBERGER	La Valorisation des Rôles Sociaux Edition des Deux Continents GENEVE

Organisation: Comité Européen pour le Développement de l'Intégration Sociale (European Committee for the Development of Social Integration – CEDIS)

Country: France **Type of organisation:** Non-profit association

Main activity: promoting social integration, research, training for adults in the social and social-medical sector.

Contact : Aurore BARBASTE **Email :** ass.cedis@wanadoo.fr

Phone : +33 5 53 475 735 **Website:** http://www.cedis-europe.org

Organisation: Siksali Development Centre

Country: Estonia **Type of organisation:** NGO

Main activity: Training and development for adults in rural environment in south-east Estonia.

Contact : Kaidi-Mari LIPING **Email :** kaidimari@siksali.ee

Phone : +372 55 655 172 **Website :** http://www.siksali.ee

Organisation: Altea-España

Country: Spain **Type of organisation:** Non profit association

Main activity: Research and training in the social sector, promotion of social and professional integration for disadvantaged youths

Contact: Rosario RICO **Email :** altea-europa@ctv.es

Phone : +34 966 880 114 **Website:** http://www.altea-europa.org

Organisation: Questão de Equilibrio

Country: Portugal **Type of organisation:** Non profit association

Main activity: Promotion of social integration, reserach, training for adults in the social and medical-social sector.

Contact: Maria Paula COSTA PINHÃO MARTINEZ MARQUES

Email : questao.de.equilibrio@netvisao.pt

Phone : ++351 265 237 773 **Website :** www.questao-equilibrio.org

Organisation : SOS Children Village Association of Latvia

Country: Latvia **Type of organisation:** Non profit association

Main activity: SOS Children Village is a social charitable organisation looking after children orphans, abandoned or whose family situation requires long-term placement. The objective is to allow these brothers and sisters to grow up together in the warmth and safety of a familial environment. The organisation also works to strengthen families.

Contact: Sandra BRAUNERE

Email : sandra.braunere@sosbca.lv **Phone :** +0371 677 378 353

Website: http://www.sos-childrensvillages.org/Where-we-help/Europe/Latvia/Pages/default.aspx

Organisation: **LEAM Développement et Gestion de Projets**

Country: France **Type of organisation:** Consultancy

Main activity: LEAM assists associations and businesses in their projects of european development and cooperation, helping them to secure the european funding relevant to their needs.

Contact: Anne-Marie LE **Email :** contact@leam-conseil.com

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