Kent and Medway
NHS and Social Care Partnership Trust

Crisis Resolution & Home Treatment Service Operational Policy (Standard Operating Procedure)

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DOCUMENT TRACKING SHEET

Crisis Resolution & Home Treatment Service Operational Policy

Version	Status	Date	Issued to/approved by	Comments
V0.1	draft	18/05/10	CRHT Steering group	
V0.2	draft	28/05/10	CRHT Steering Group	Minor amendments re wording completion of EIA and appendices
V0.3	draft	9/06/10	CRHT Steering Group	Minor amendments to sections 4, 5, 6, 7, 9, 10, 15
V0.4	draft	2 /07/10	CRHT Steering Group Acute Service Line	Amendment to 9.1 SECAmb refer to FRIS in hours not CRHT 10.5.5 added and complete cpa documentation 11.2 added need to complete CPA 2 &4 as minimum standard
V0.5	Final draft	22/10/10	Acute Service Line	Minor adjustments reflecting future change in paperwork Adjustments to format.
V1.0	Final draft	23/11/10	Acute Service Line – clinical governance group	Approved for use
V1.1	Review	/12/11	Acute Service Line clinical governance group.	- updated to reflect acute care pathway, introduction of RiO
V1.2	Review	15/04/2013	Acute Service Line clinical governance group	10.13 added to include CRHT support during leave
V2.0	Review	July 2015	Acute Service Line clinical governance group	Overall review
V3.0	Full Review	14/06/2016	Acute Service Line clinical governance and patient safety	Full policy review against practice changes and learning.
V3.1	Full Review	12/04/2019 - 5/09/2019	CRHT HBPoS care unit; Acute Care Group/ Older Adults care group/ CEOG	Updated to reflect patient flow; CRHTT fidelity model standards; interface with Support and Signposting
V.4.0	Final	24/09/2019	Clinical Effectiveness and Outcomes Group / Trust Wide Patient Safety and Mortality Review Group	Approved

V4.1	Final	18.10.2019 26.11.2019	Addendum to V4.0 Acute Care Group Clinical Effectiveness and Outcomes Group (CEOG)	Section 10: Escalation process for MHA that are delayed. Section 12 and appendices G1-3: Medication pharmacy – update on process, protocol and charts. Addendum to V4.0 approved by CEOG.

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Department of Health (2008) *refocusing the Care Programme Approach: policy and positive practice guidance* London: HMSO
NICE Guidance
NHS England investment in mental health 2015/16 – a note to accompany the 2015/16 National Tariff Payment System – a consultation notice

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

Operational Policy Addendum (MHLD Feb 10)	Feb 2010
MHLD Key Principles	Feb 2010
Staff Briefing (MHLD Feb 10)	Feb 2010
KMPT Missing Persons Policy, Acute Welfare – Check policy	June 2016
S136 Policy (currently under review)	June 2016
Acute Inpatient Operational Policy	June 2016
CAMHS Operational Policy	June 2016
CPA Policy	June 2016
Service Line Strategies (including briefing document)	June 2016
KMPT MH Pathway	June 2016
Acute Care Pathway	June 2016
Patient Flow Policy	July 2018
Clinical Indicators for Acute Care	November 2018
Acute Service Admission and Discharge Protocol	
Admission & Discharge Policy for Older People Services incorporating the Choice	KMPT.CLiG.083
Care Programme Approach Policy	KMPT.CLiG.001
Clinical Risk Assessment & Management of Service Users Policy	KMPT.CLiG.009
CMHT Operational Policy	KMPT.CLiG.121

Delivering Same Sex Accommodation Policy	KMPT.CLiG.139
Draft NELFT CAMHS	
Health and Social Care Records Policy	KMPT.CLiG.071
Infection Prevention and Control Policy	KMPT.CLiG.005
Informal Patients Policy	KMPT.CLiG.022
Medicines Management Policy	KMPT.CLiG.008
Mental Capacity Act	KMPT.CLiG.052
Mental Health Act Code of Practice 1983 – revised 2008	DH 2008
NICE Implementation Policy	KMPT.CliG.028

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
18.10.19	Service Manager CRHT & HBPoS	13	Escalation process for MHA that are delayed
18.10.19	Service Manager CRHT & HBPoS	18 - 22	Medication and Pharmacy section: rewrite in conjunction with Drugs and Therapeutic Committee – updated processes and protocols
18.10.19	Service Manager CRHT & HBPoS	45 - 48	Appendices G1-3: updated medication charts, forms and guidance diagrams

CONTENTS

1 EXECUTIVE SUMMARY

1.1 'The philosophy of the Kent & Medway Crisis Resolution & Home Treatment teams (CRHTT) is to deliver safe, appropriate and effective home based treatment in the least restrictive and most appropriate environment as an alternative to hospital admission in order to facilitate a resolution to the presenting acute mental health crisis'.
In conjunction with the Patient Flow Team, the CRHT also have responsibility for the gate keeping of admissions to manage the use of adult acute beds across the trust.

1.2 **The Acute Care Pathway**

1.3 The focus in the development of mental health services has in recent years been the focus on the expansion of community service provision. The Mental Health Policy Implementation Guide for Adult Acute Inpatient Care Provision (MHPIG) DOH-2002 did however describe an "acute care pathway". The key components were described as crisis, admission and timely discharge and the core services would be the inpatient wards and CRHT teams.

1.4 A vision and set of principles for acute care can be found in the DOH guidance Our Future, Our NHS (2007) and the "Acute Care Declaration" as provided by the National Mental Health Development Unit and Mental Health Network.

1.5 Acute care pathway services are focused on achieving the best possible outcomes for people during times of mental health crisis. The best acute mental health care supports the development of a specialist acute care workforce that plays a vital role in keeping people safe and helping them achieve recovery. This includes the provision of high quality acute care delivered by services that are safe for everyone in the least restrictive settings, where a culture of therapeutic optimism supports recovery and personal responsibility, that is sensitive to spiritual and cultural needs, where effective evidence based treatments are delivered in safe and clean environments and where there are better mental and physical health and quality of life outcomes. Acute services are orientated to the strengths and abilities of people and promote recovery and social inclusion to ensure people remain a part of their local community when acutely ill.

1.6 In February 2014 22 national bodies (since this date a further 5 bodies have signed up, making the total now 27) signed up to the crisis care concordat. This is a national agreement between agencies involved in the care and support of people in crisis. It sets out how organisations will work together to better ensure service users get the help and support that they need at the point of mental health crisis. This document is particularly pertinent to CRHT services and must feed in to the 4 main areas of the concordat document:

1.6.1 Access to support before crisis point

1.6.2 Urgent and emergency access to crisis care

1.6.3 Quality of treatment and case when in crisis

1.6.4 Recovery and staying well

1.7 All acute services should therefore

1.7.1 Offer fair, personalised and safe care

1.7.2 Offer care that optimises engagement, and manages risk

1.7.3 Ensures users and carers have a care plan that includes action to be taken in a crisis

1.7.4 Is accessible 24 hours, 365 days a year and when support at home is not possible is able to offer timely access to an appropriate hospital bed in the least restrictive environment that includes effective and comprehensive discharge planning

2 INTRODUCTION

2.1 In 2015 NHS England pledged £80 million of investment in mental health care. The work towards parity of esteem for mental health care, NHS England also looks towards introducing waiting time standards for mental health, previously excluded from the NHS Consultation guarantees.

2.2 In the last decade Crisis Resolution Home Treatment (CRHT) services have been developed to provide acute care for mental health service users living in the community and experiencing a severe crisis requiring emergency treatment. Previously, such treatment could only have been provided by admitting the service user to an inpatient ward. The introduction of CRHT services was one of the key elements in the 1999 National Service Framework for mental health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health's 2002 Public Service Agreement included targets both for the number of teams and the number of people treated. The main aim was to provide service users with the most appropriate and beneficial treatment possible. But CRHT was also intended to reduce inpatient admissions and bed occupancy, support earlier discharge from inpatient wards and reduce out-of-area treatments (where a bed can only be found for a person outside local NHS services).

3 PURPOSE

3.1 The CRHT Team is available 24 hours a day, 365 days per year to provide timely assessment and treatment to residents within Kent & Medway Partnership Trust (KMPT) boundaries who are experiencing a major mental health crisis, and to support their relatives, carers and social systems to resolve the crisis.

3.2 As far as possible, the service will be provided in the persons own home in order to enable the service user to be cared for in familiar surroundings and in a manner which promotes independence, choice and recovery. The CRHT Team will be able to facilitate the process of admission to hospital if preferred home-treatment options are not appropriate or not achieving the desired therapeutic effect.

3.3 Once the crisis is resolved, the service will ensure that the service user and their relatives or carers are linked to ongoing treatment within the CPA framework if required, both in the resolution of the crisis and in identifying ongoing care. The team will work with the service user, their carer's, existing social supports, voluntary and other involved agencies, GP's and the service users Care Co-ordinator / Lead Professional to ensure a seamless approach to care.

3.4 KMPT has a socially diverse population, and by working with service users in their own communities, it is aimed to ensure that the team offers care that is sensitive and appropriate to the individual's circumstances, gender and ethnicity. The Trust

is committed to ensuring appropriate training is provided to staff to ensure that they are able to provide sensitive and skilled care.

3.5 Safe and effective short-term care support and treatment will be at the heart of all negotiation with the service user. Clear information will be provided to inform choice and to facilitate proactive work with service users and their carers/advocates. The team will strive to provide a plan of care that reflects the views of its service users, that is safe and effective, and which is subject to regular review.

4 DUTIES

4.1 Provide intensive community based treatment to service users in the acute phase of mental illness, thus diminishing the need for hospital admission.

4.2 The CRHT Team will provide a 'gate-keeping' role to all working age adult acute in-patient beds.

4.2.1 Where necessary to provide effective support and management of risk in the community where a bed is not immediately available

4.3 Provide a timely response to crisis, 24 hours a day, and 365 days per year. Emergency referrals are to be seen face to face within 4 hours, and urgent referrals within 24 hours.

4.4 Where there are unforeseen gaps in the Place of Safety, CRHT will provide the necessary staff to ensure the suite remains open. Where there is difficulty filling the gap via CRHT, discussion will be held with the Clinical Service Manager for HBPoS/West Kent CRHT (in hours) and the Clinical Lead (out of hours) who will look at all possibilities. Closure of the suite will be the last option considered.

4.5 Facilitating the early discharge from hospital where hospital admission has already been necessary (for service users who in the absence of the CRHT Team would have to remain in hospital).

4.6 Provide support to service users taking leave to the community from the inpatient unit for periods exceeding 3 nights, or where risk indicates the need for this input. This should be considered also if there are concerns raised by carers about coping with leave periods.

4.7 Make full use of all community resources, with a particular focus on the service users' own social support networks.

4.8 Provide an integrated mental health service, liaising with other statutory and independent mental health service providers and providing documented involvement with other providers where appropriate, and where there is information sharing agreements in place.

4.9 To support CMHT to provide 72 hour post discharge from inpatient setting follow up face to face contacts. CRHT will provide this service for those discharged on Thursdays and Fridays. On Bank Holiday weekends CRHT will also provide face to face 72 hour follow up contact for those discharged on a Saturday (and those discharged on Good Friday). This contact will usually occur within 24 hours of discharge.

4.10 Following 72 hour face to face contact an individual may be taken onto CRHT caseload for a period of intervention; transferred to CMHT for further appointment within 7 days or discharged to primary care. Risk assessment and patient action plan will be completed at point of contact.

5 KEY CHARACTERISTICS & PRINCIPLES

5.1 At the point of referral, a multi-disciplinary assessment is aimed for and alternatives to admission considered.

5.2 Signpost to appropriate services/ agencies as appropriate.

5.3 Facilitate a timely discharge from an acute inpatient stay in hospital, providing where appropriate intensive home treatment.

5.4 Intensive short term interventions are provided usually up to a maximum of 4 weeks.

5.5 The service is provided within the service user's local community with as little disruption to the person's normal routine as possible; this could be a home environment, or another venue of the service user's choice. CRHT's across Kent work collaboratively to provide a local response to the patient even if staying away from normal address.

5.6 The team seeks collaborative involvement of the service users family, carers and/or significant others to support and promote the individuals recovery.

5.6.1 In the event of no consent being obtained to work with carers, every effort will be made to still listen and obtain information and access to support services.

5.7 Working in parallel with care coordinators/ Lead Professionals, Community Mental Health Teams (CMHT), Community Mental Health Services for Older People (CMHSOPs), GPs, Teams for people who have a learning disability (TPLD)-where appropriate- and other agencies involved in the service users care, including for example drug and alcohol services or probation services.

5.8 Involvement continues until the crisis is manageable, evidenced by robust risk assessment, resolved or a level of wellness has been achieved to support transfer or facilitate early discharge where appropriate.

6 ACCESS CRITERIA

6.1 The person is experiencing an acute disruption in their ability to function adequately in the community – primarily as a result of an acute mental health problem of such severity that without the involvement of CRHT hospitalisation would be necessary.

6.2 The person meets the criteria for secondary mental health services and is at risk of admission to a psychiatric inpatient hospital.

6.3 The person is 18 years of age or over and suffering from a functional mental illness

6.4 They are inpatients for whom discharge can be facilitated by the provision of intensive home based treatment.

6.5 The person is currently an inpatient on a mental health ward, but is being given a trial leave period in the community that extends for 3 days. Or there are risks indicated during a trial leave period that indicate the need for CRHT input, this could be to support carers.

6.6 The service is provided to service users within the catchment locality of the team, or the team most local to a temporary address. For service users out of area the CRHT will assist in the repatriation of the person to their own locality and liaise with their mental health services as appropriate.

6.6.1 Repatriation or relocation will be supported by precise documentation as to location, address and support.

6.7 Service users requiring long term intensive support will not normally be appropriate for CRHT service. This service is not usually appropriate for individuals with:

A. Mild anxiety disorders

B. Primary diagnosis of alcohol or other substance misuse

C. Brain damage or other organic disorders including dementia although patients in the milder stages of dementia with functional psychiatric symptoms should be considered for crisis home treatment

D. Where there is significant crisis related purely to social issues or relationship issues CRHT services are <u>not</u> normally appropriate, however to manage risks and provide support to prevent future access to secondary care services, CRHTs may decide on short term input and signposting care.

7 STAFFING AND TEAM STRUCTURE

(Appendix C; see local team information at CRHT base)

7.1 Currently teams vary in their composition, but can include the following mental health workers

- Consultant Psychiatrist
- Specialty Doctor
- CRHT Manager (In varying formats – some teams may comprise of both an operational and clinical manager as separate roles).
- Mental Health Community Nurses
- Nursing Associate
- Occupational Therapist
- Pharmacist
- Psychologist
- Peer Support Worker
- Support Time Recovery Workers
- Administration Staff
- Clinical Nurse Specialist (Non- Medical Prescriber)

7.2 Staff adopt a flexible working shift pattern which meet needs of the service.

7.3 CRHT is part of the wider services delivered by the Acute Care Group. Within the Acute Care Group it provides an integrated model of care which enables staff to have the opportunity to participate in internal rotation and joint training opportunities.

7.4 The service provides development and education opportunities for students (SHO; GP trainees; nurses; OT; Social Workers, etc).

8 MEDICAL RESPONSIBILITY

8.1 When a service user known to the service (and therefore under the care of a Consultant) is accepted onto the CRHT Team caseload, medical responsibility is temporarily assumed by the CRHT Team Consultant(s).

8.1.1 Where there is specialist consultant input such as MIMHS teams will maintain contact.

8.2 When a service user new to the service is taken on by the CRHT Team, the Locality Mental Health Service (CMHT/ or CMHSOP) Consultant is identified but medical responsibility is temporarily assumed by the CRHT Team Consultant.

8.3 When an inpatient is discharged from ward care to the CRHT Team, medical responsibility is transferred to the Consultants within the CRHT Team (if medical cover in inpatient differs from the CRHT Team).

8.4 When a CRHT Team service user is admitted to an inpatient ward, medical responsibility is assumed by the relevant Inpatient Consultant (if cover differs from CRHT).

8.5 If medical intervention is required ‘out of hours’, relating to a Mental Health problem, the CRHT Team will access the ‘on call’ psychiatrist for advice and guidance or duty SHO for a physical health problem the team will access the ‘on call’ GP.

8.6 GPs will retain responsibility for physical health needs.

8.6.1 CRHT’s will seek confirmation of medical history via GP on acceptance to CRHT.

8.7 Be available to team members for consultation and advice regarding clients on the caseload.

8.8 Review clients on the caseload.

8.9 Work closely with other colleagues and services to ensure continuity of care for the clients when they move to/from CRHT.

8.10 To provide clinical leadership to the team in conjunction with locality team managers.

9 PATHWAY

9.1 In working hours most referrals come from secondary care community mental health teams, specialist psychological services (under the Personality Disorder Pathway), and the police.

9.2 Out of Hours (OOH) referrals may come from

- Single Point of Access (SPoA)
- Police
- Service users*
- Acute hospital A&E departments for screening/secondary care gatekeeping assessments – except where there is liaison psychiatry provision in place. These referrals will be seen within 4 hours as per CRHT urgent response.
- *Service users who are known to secondary care can contact CRHT directly OOH in a mental health crisis as indicated in their crisis contingency care plan. Their concerns will be documented, screened and responded to in an appropriate and proportionate manner.

9.3 Those seeking support who are not known by secondary services will access this support via single point of access (SPoA). SPoA will then screen and direct the individual to the correct service.

9.4 Those seeking support who have been previously known by CRHT but are no longer under secondary care will access support via SPoA. SPoA clinicians complete a tele-triage on behalf of CRHT and deem whether to discharge back to care of GP or to refer onto relevant CMHT/CRHT. In all instances referrals will be screened & decide appropriateness for service; those not requiring acute care will be signposted to the relevant service those deemed appropriate will be assessed and offered the appropriate intervention.

- All instances where a referral is screened this will attract the minimum of screening form and progress note on RIO.

10 MODEL

10.1 **CPA / Community Team Interface:**

10.1.1 The responsibility for Care Co-ordination / Lead Professional for existing service users remains with the CMHT/CMHSOP. Their involvement throughout the process of care whilst the CRHT Team are involved provides continuity for the service user, and the level of consistency required maintaining effective liaison between CMHT/CMHSOP and the CRHT Team. It is expected that there will be joint work between visits where ever possible.

10.1.2 The CRHT Team will not take on the role of Care Co-ordinator / Lead Professional within the CPA process. If a person is accepted to the CRHT caseload out of hours, not known to the CMHT/CMHSOP, CRHT will inform CMHT/CMHSOP on the next working day, in order to ensure follow-up arrangements are in place.

10.1.3 The aim of provisional Care Co-ordination is to ensure the CPA requirements are met, including the completion of initial CPA documentation, once a service user is accepted by the service with a view to handing over this responsibility to an allocated Care Co-ordinator

10.1.4 / Lead Professional within the CMHT/CMHSOP as soon as possible.

10.1.5 Where there is an existing Care Co-ordinator / Lead Professional within the CMHT/CMHSOP:

a) The opinions of the Care Co-ordinator / Lead Professional will be taken into account at all times.

b) The Care Co-ordinator / Lead Professional will liaise with the CRHT Team on at least a weekly basis to discuss the service user's progress.

c) Any major changes to the service user's plan of care, wherever possible, will be discussed with the service user's Care Co-ordinator / Lead Professional.

d) Joint visits will take place to ensure the involvement of the Care Co-ordinator / Lead Professional is maintained where possible.

e) CMHT/CMHSOP will maintain contact with their service user throughout their time within acute care services.

f) CRHT care plan will be opened in addition to that prepared by the care coordinator.

10.1.6 Any care coordinator involved with the service user, must in all instances remain the lead professional for the service users care, the CRHT services augment the existing care package at times of crisis and are not to replace it, or take this care over entirely

10.2 **Referrals & Alerts**

10.2.1 All requests to admit a service user by the community mental health teams/GP must be referred to the CRHT team in the first instance. The CRHT team will undertake an assessment and decide whether they can provide an alternative to admission.

10.2.2 The referrer will be required to evidence that in the absence of the CRHT service providing intensive short term input, the service user would require admission. This would be evidence via use of the clinical indicators for admission outlined by the Patient Flow Team.

10.2.3 The referrer will ensure the CRHT team are made aware of the urgency and degree of risk the service user poses to self and others. In discussion with the shift co-ordinator, and supported by risk assessment, core assessment and HoNOS assessment documented on RiO to coincide contemporaneously with the date of referral

10.2.4 Referrals are recorded on RiO including demographics, CORE assessment & risk assessment. HoNOS and clustering will also have been completed. Referrers need to contact the CRHT and discuss the referral. A faxed referral without any discussion will not be accepted by the team.

10.2.5 At the time of referral it is expected that all demographic details have been confirmed and updated if necessary. This must include, names, and telephone contacts as a minimum for the carer or relative.

10.2.6 All referrals will be directed to the CRHT Team. The Team will screen referrals and decide on appropriateness to the service. If deemed

appropriate, the team will assess and provide the required crisis intervention and intensive support until the crisis is resolved. Where appropriate a joint assessment will be conducted following a referral to acute care services. The referrer will be expected to have had a face to face contact with the service user in the 24 hours prior to referral to CRHT, and have completed a risk assessment, update the core assessment, and HONOS and cluster, and provide a progress note entry.

10.2.7 In the event that the CMHT/CMHSOP become aware on an individual who may benefit from CRHTT involvement but have been unable to contact and review but significant concerns are present re individuals mental state/wellbeing that this is discussed with the CRHTT team leader to agree a considered way forward which may involve CRHTT accepting case for assessment in absence of CMHT/CMHSOP contact. This would be in exceptional circumstances on a case by case basis and not general practice

10.2.8 CRHT will complete referral outcome form on the Trust electronic system (RiO).

10.2.9 Where the service user's primary diagnosis is organic in nature, CRHT may be unable to provide full services however should provide support and signposting for carers.

10.3 **Out of Hours**

10.3.1 To include Bank Holidays/Weekends and within the hours of 17.00 and 09.00 Monday to Friday

10.3.2 The CRHT take on the function of the Single Point of Access (SPOA)

10.4 **Assessment**

10.4.1 Assessment should take place in the most appropriate environment for the service user based on current risk assessment.

10.4.2 Wherever possible the assessment will be carried out with the referrer, to minimise duplication and reduce distress to the service user.

10.4.3 Wherever possible the assessment will involve/include the service user's relatives/carers or significant others and this should then be documented clearly within the care and risk assessment.

10.4.4 Wherever possible the assessment will involve/include the service user's existing clinical support teams (including where appropriate, CMHT, CMHSOP, TPLD, MHLD, etc.)

10.4.5 Assessments will be carried out in line with the Trust CPA policy and the appropriate documentation completed (demographics, core assessment, risk assessment, HoNOS, Clustering).

10.4.6 In all assessments, staff will confirm and document within demographics the carer and next of kin details. Staff will also confirm the demographics pertaining to the service user themselves

10.4.7 The decision to admit or not will be based on the level of risk identified and how best to manage the identified risk. The decision is made by CRHT teams following discussion with Patient Flow Team.

10.4.8 Where CRHT Team involvement is not indicated, or is not acceptable to the service user, options include:

a) Referral back to referring agent

b) Referral on to more appropriate mental health services – where there is evidence of mental health problems which do not require CRHT Team intervention.

c) Assessment under the Mental Health Act

d) Informal admission

10.4.9 Where the service user declines CRHT input when offered clear statement in capacity, and any carers or family members thoughts must be clearly documented.

10.5 Risk Assessment & Management

10.5.1 The decision as to whether to offer home based treatment or to admit to an inpatient unit will often be influenced by the level of risk. It is therefore essential that there is an emphasis on risk assessment in the CRHT Team assessment process. Because of the nature of the service, assessment and management of risk play a major role in the day to day working of the CRHT Team.

10.5.2 Risk will be managed in line with the Kent & Medway Partnership Trust CPA Policy section on risk assessment and management and will include the following:

a) Access to all relevant information from the referrer/CMHT/CMHSOP including the most recent risk assessment.

b) Assessments are made by at least two CRHT Team clinicians and in consultation with the Shift Co-Ordinator and if necessary the CRHT Team Consultant and CRHT Team Manager wherever possible.

c) The CRHT Team discuss and review all service users currently being seen by the team on a shift by shift basis. Risk will always be considered at these meetings and interventions may be altered accordingly. Documentation must be completed by assessing team and any discrepancy noted.

d) On each contact the level of risk will be re- assessed and the level of input adjusted accordingly, and where indicated the risk assessment form will be updated. The risk level will be already indicated by way of both risk assessment and traffic light status (RAG rating). Where a service user has need and risk current rating of red then they will be seen by a qualified practitioner.

e) Where risk is a major identified factor visits will be undertaken in pairs. This will facilitate joint decision making regarding risk re-assessment and risk management. This also takes into consideration of specific gender working both according to risk and service user culture.

f) Access to medical support is available 24hrs a day.

g) Service Users awaiting admission in the community are to have a member of staff with them at all times. Where this is not possible or the Service User declines this, the duty can be delegated to a family member or carer on the

understanding of full responsibility. In such circumstances agreed times for twice daily home visits will continue to be in place

h) Where there are issues that mean that teams cannot achieve any part of this policy they must use the escalation process. Staff will notify the most senior clinician; this may be their line manager or clinical lead. It will then be decided if there are actions that could be taken to achieve the policy requirements, and if the situation requires further escalation to senior management.

i) Where there are issues with staffing the service, in the adherence to this policy staff must follow the escalation policy, the service must be driven by need, and not by capacity.

10.6 Patient Transport

10.6.1 Transport of service users and or carers, must be done in concordance with the trust policy on transporting patients.

a) The vehicle used must be one that is appropriate for the transportation of individuals having considered all the relevant the risk factors, with the avoidance of secure vehicles wherever possible.

b) Staff ratio must be based on the management of the identified risk.

c) Staff must ensure they have informed their manager or the most appropriate member of staff of their intended journey (in line with the local Lone working protocols)

10.6.2 Staff must work within the DATIX recorded health and safety assessment in Relation to transportation, and in accordance with the Trust patient transport policy

10.6.3 Where staff are facilitating longer journeys with service users, particularly where sedation has been given in advance of the transfer, staff must in all instances ensure that they have with them emergency medical equipment, contained within grab bags

10.7 Service Delivery and Interventions

10.7.1 CRHT Team service users will receive intensive home based treatment and support, this being the primary role of the Service.

10.7.2 Service user contact is short term, usually spanning a period comprising no more than 4 weeks. Frequent and intensive contact is provided on an outreach basis during the period of mental health crisis and up to the formal transfer of ongoing and direct responsibility to the CMHT/CMHSOP Care Co-ordinator / Lead Professional, GP or other agency.

10.7.3 The service user, their carers and significant people from their social network are invited to participate in planning interventions, to offer options and explore possible consequences of each option available. These discussions should be clearly documented on RIO.

10.7.4 The service user and carers will be involved and informed as and when the care plan is changed according to circumstances and need.

10.7.5 Where the service user no longer wishes their carer or family member to be involved in their care then the CRHT must ensure that the carer/family

member is supported and time is given for concerns which they may have to be ventilated.

10.7.6 CRHT Team will provide a service which will incorporate:

The location where care is provided

a) The timing and purpose of visits

b) Psycho-social interventions to assist the service user/carers to understand their experiences and develop coping strategies

c) Details of how to contact the CRHT Team in an emergency

d) Medication details and the choice with regard to medication agreed

e) Expectations of the service user/carer

f) The role of carers and others in the service users social network

g) The role of the GP

h) Involvement of other specialist mental health services (e.g. CMHT, CMHSOP, MHLD)

i) Involvement of other specialist clinical services e.g. TPLDs in the case of service users who have a learning disability.

j) The use of an inpatient admission (if appropriate) (including specialist inpatient services for service users who have a learning disability, e.g. the Assessment and Intervention Service).

k) Early discharge planning

l) Risk assessment/ management

m) Agreement of action in crisis

10.7.7 The CRHT care plan will run alongside any care provided from the CMHT, CMHTOP or MHLD.

10.7.8 The CRHT will work collaboratively with the service user to develop a person centred crisis care plan which will be available on RiO. The process of care planning will commence immediately on acceptance to CRHT.

10.7.9 It will be expected that the care coordinator / Lead Professional and the CRHT will work in close partnership in the provision of care to the service user. The care coordinator/ Lead Professional responsibilities will remain the same.

10.7.10 Care plans will be reviewed on a minimum of a weekly basis and amended/altered in accordance with progress/need/risk, with supporting documentation. In addition daily action plans are reviewed at each contact and updated.

10.8 **Social Systems and Carers**

10.8.1 Social system support and carers are often a critical component of home treatment.

10.8.2 Social system support and carers will be identified in order for their perspective to inform the assessment process and their contribution be included in the crisis care plans with the service user permission. The CRHT Team will provide information to carers:

a) About the CRHT Team – How it works and how it can be contacted at any time if the carer has any problems

b) The service user's Care Plan – planned interventions and the roles of the people involved as agreed by service user.

c) Signposted to where they may be able to further access support services such as advocacy, practical assistance, carer's support groups, etc.

d) CRHT acknowledge that Carers are a key partner in the provision of care whilst the service user is in receipt of home treatment. The carer will be offered support and time to voice their concerns and or general support from CHRT. This will be offered regardless of service users consent to the carer's involvement in their treatment plan.

e) These are arrangements that remain standing regardless of patient consent to sharing information with carers.

10.9 **Home Treatment:**

10.9.1 CRHT Team treatments and interventions are short term, and in most cases up to four weeks. They focus on safety, choice, recovery and empowerment of service users, their carers and social systems during periods of mental health crisis. All treatments are based on appropriate assessment procedures.

10.9.2 Service users are encouraged to participate in the development of their treatment plans and to take the appropriate level of responsibility for aspects of their treatment.

10.9.3 CRHT Team treatments complement and support the service user's existing care.

10.9.4 At the earliest opportunity a meeting or contact will be set up with all the people involved in supporting the service user (social system) until the resolution of crisis.

10.9.5 CRHTs may have to transfer care to a counterpart team. However, where this is likely to be damaging to the service users recovery, this may be reviewed to achieve more positive outcomes. It may be necessary for CRHTs to cross boundaries and work within other localities, where this is practical and reasonable, for the benefit of the service user

10.10 **Inpatient Admission:**

10.10.1 Inpatient admission is considered when the needs of the service user are beyond the resources of the team to safely fulfil the needs identified in the assessment.

10.10.2 Where the level of observation, monitoring and care is beyond that which the CRHT team can provide in conjunction with the support from the relatives/carers/significant others, to prevent a serious deterioration in the service user's health or leaves an unacceptable degree of harm by the service user to either themselves or others. CRHT will consider at this point whether an informal admission is offered; admission under the Mental Capacity Act if criteria is met or an assessment under Mental Health Act is required.

10.10.3 Where there is any risk to children / vulnerable adults or a serious risk of attack to the service user by others due to their behaviour. Where this exists, there will be full documentation and safeguarding referrals.

10.10.4 The Acute Care Service will provide the service user with the CRHT leaflet

10.10.5 (Appendix E), which provides information on services provided by CRHT and early discharge planning. Early discharge planning should be included in the Acute Care, care plan.

10.10.6 Detained under the Mental Health Act (MHA). If the service user under CRHT is requiring inpatient care and lacks capacity to consent to this, CRHT will contact the relevant Approved Mental Health Practitioner and request a MHA assessment providing relevant information including current concerns and risks. Should there be a delay in responding to CRHT request for a MHA assessment CRHT staff should follow the following escalation process:

- In Hours - escalation via team manager in the first instance who will liaise directly with AMHP Team Leader. If still no response then this will be escalated to the Clinical Service Manager and then Service Manager who will liaise with AMHP Service Manager. If still no response then further escalation will be made via the Head of Service.
- Out of Hours: escalation will be via the clinical lead in the first instance who again will discuss with the AMHP Team Leader/Co-ordinator escalating to the manager and director on call if resolution not achieved.

10.10.7 The wishes of both service user and relative/carer/significant other will be considered

10.10.8 CRHT will be responsible for arranging admission

10.10.9 Planned admissions for specific intervention which cannot be carried out safely at home

10.10.10 24/7 bed management function is provided by the Patient Flow Team.

10.10.11 Documentation of assessment (CORE and Risk) on RiO, however where there is a delay in inputting these then admission should proceed with paper documentation. The electronic system should be updated as soon as possible. Admission should not be delayed as a resulted of information not placed on the electronic record.

10.10.12 Determining at the outset the “purpose of admission” is central to the acute pathway and is key to the recovery/psychological mindedness ethos of the service.

10.10.13 Wherever possible KMPT beds should be facilitated, however where this is not possible, it is accepted that private beds may need to be used within established providers. The Patient Flow team will support the identification of bed to be used.

10.11 **Discharge from the ward and transfer to the CRHT**

10.11.1 Patient status reviews will consider possible discharge date, progress and proposed date for discharge will be communicated to the Care Co-ordinator /lead professional.

10.11.2 CRHT will endeavour to provide a representative at the weekly bed management meeting to identify any service user who may benefit from CRHT input on discharge. Attendance can be virtual.

10.11.3 CRHT provides a representative to participate in the Older Adults bed management weekly conference call, where they will identify any service user who may benefit from CRHT input on discharge. Attendance can be virtual.

10.11.4 CRHT Team clinicians are responsible for contributing the components of the discharge plan which relates to CRHT Team involvement.

10.11.5 Discharge planning for 'out of area' service users must be negotiated between the inpatient service and the CMHT/CMHSOP in the area to which the service user will be discharged. Where CRHT input is required then discharge plan will also need to be negotiated with the CRHT in the area where the service user will be discharged. Contact details for each CRHT Team are available in the appendices and available on each inpatient ward as well as on the KMPT intranet.

10.11.6 The inpatient team making the decision to transfer an inpatient's care to the relevant CRHT Team must ensure that this transfer is arranged safely, ensuring that the following steps are taken:

(i) Designated Ward registered or associate nurse will speak via the telephone to the relevant CRHT's shift coordinator and convey the service user's details and treatment needs.

(ii) Designated Ward registered or associate nurse will record above discussion on RIO and agree with the CRHT shift coordinator the date and time that the CRHT will make the first visit to the service user at home.

(iii) The Service User will be provided with the date and time of the CRHT visit and the contact details of the CRHT by the Ward registered or associate nurse.

f) Where an out of area or private bed has been used to facilitate the patient's admission, it may not be necessary for the service user to come via the CRHT automatically. However the discharge process should consider this an option, and document accordingly in each case.

10.11.7 Where the service user is residing in a different area from their registered GP the CRHT team which is local to their area of residence will provide input as required.

10.11.8 Where service users relocate to another area before the end of CRHT input there must be an ongoing referral to a CRHT in the appropriate area.

10.12 **Inpatient Early Discharge Planning needs reviewing in light of patient flow/discharge co-ordinators**

10.12.1 Early Discharge Planning is distinct from the established process of discharge planning for inpatients. The objective is to reduce the patient's length of stay in hospital. The distinguishing factor is based on the identified reasons and risk factors for hospitalisation. Once these factors have been addressed the patient can be discharged from hospital to the ongoing care of CRHT Team.

10.12.2 Early Discharge Planning will be available to all adult inpatients (18 & over) with functional mental illness whose identified reasons for hospital admission have been addressed and acute care can safely be continued at home.

10.12.3 Where the service user is an inpatient in a different locality to that of their home CRHT / CMHT/ CMHSOP / place of residence and facilitated Early Discharge is recommended, discussion between the local CRHT and the patients home CRHT team should occur. If early discharge agreed the local CRHT team will review the service user, update RiO and transfer back to the home CRHT on discharge from hospital. The Care Co-ordinator / Lead Professional must be involved in the process.

10.12.4 Core assessment, Risk assessment and HONOS must be completed by the assessing team (CRHT) and recorded on the Trust electronic record system.

10.13 **CRHT Support during Leave:**

10.13.1 Leave should be agreed as part of the discharge planning process. Any patient who is going on leave for 3 days or more should have CRHT support in order that the leave can be assessed as part of early discharge plans for home treatment. A comprehensive care plan must be in place to cover the aims and objectives of leave and contingency planning should any problems arise

10.14 **Closure of CRHT Input:**

(Appendix F) Formal processes should be established in each service to ensure that closure of input from the CRHT Team is well managed. CRHT Team closure summary will identify the current treatment needs & level of risk of the service user, ongoing interventions required to support the service user and carers and expectations established with the CMHT/CMHSOP Care Co-ordinator / Lead Professional, GP and other significant people.

10.14.1 When the mental health crisis has resolved and the service user no longer needs intervention from the CRHT Team, the service user's care is usually handed over to the Care Co-ordinator / Lead Professional in the CMHT/CMHSOP.

10.14.2 Continuing medical responsibility is transferred from the CRHT Team Consultant to the CMHT/CMHSOP Consultant. The GP will be notified in all cases.

10.14.3 Cases that are ready to be transferred to the CMHT/CMHSOP and are RAG rated green are discussed and transferred via the perfect week call.

10.14.4 On closure from CRHT input service users will be given discharge action plan which outlines support available and appropriate contact numbers. A copy will be given to the service users GP and uploaded onto RiO. Appendix I.

10.14.5 Where a service user has not had involvement with secondary care mental health services prior to acceptance onto CRHT case load, and at point of closure risks and needs do not indicate that further secondary care mental health services are required then CRHT can consider discharge directly to Primary Care following MDT discussion.

10.15 **Liaison with other professions and services:**

- **Liaison with other Professionals (Appendix H – Perfect week guide)**

  To ensure continuity of care it is essential there is regular communication between community mental health centres, care coordinators, primary nurses and the CRHT team.

- **Role of Service Users**

  The CRHT aims to work in partnership with service users in the provision of care to them. Service users will be consulted about their care at all stages and will be encouraged to get involved in the decision making process towards their recovery. It is recognised that people's lives, not just their symptoms are affected and that individuals may require a range of supports and treatments to meet their recovery needs that include cultural, spiritual, psychological and social needs.

- **Role of Relatives / Carers / Significant Others**

  It is recognised that the role of relatives/carers/significant others are important in the care and management of the service user. The views and needs of the relative/carer/significant other should be taken into account as part of the assessment. Where eligible, the care coordinator will arrange for a carer assessment to take place. Where appropriate, relatives/carers/significant others will be fully involved in the development of a care package and of a care plan. They will be offered support as appropriate and wherever possible be fully involved in the decision making process. Where there is no consent to share information in place, carers receive the same levels of support and information can still be taken from them to inform care decisions.

- **Role of Advocacy**

  The CRHT service will encourage and support the use of advocacy services for service users and their relatives/carers/significant others. They will provide contact details and organise interviews as appropriate.

- **Role of GP's**

  The CRHT service will work closely with the service user's GP, seeking their views and keeping them informed of their service user's progress. They will be invited to attend meetings where appropriate.

- **Relationship with Approved Mental Health Practitioners (AMHP) Out of Hours**

  All requests for a MHA assessment out of hours will go through directly to the 24 hour AMHP services. CRHT will, when consulted, advise regarding possibility of home treatment.

- **Relationship with Inpatient Staff**

  Following allocation of bed by Patient Flow, CRHT staff will liaise closely with ward staff to ensuring all relevant information and documentation has been completed can communicated.

- **Caseload:**

  KMPT CRHT services operate a caseload ceiling dependent on needs/demands of service, resource and risk factors. Decisions around

caseload will be made by CRHT manager and in discussion with acute service manager. Should there be a reason to reduce caseload ceiling– this must be discussed with the assistant director for the area in question

11 DOCUMENTATION & RECORD KEEPING

11.1 A service user's record is a basic clinical tool used to give a clear and accurate picture of their care and treatment, and competent use is essential in ensuring that an individual's assessed needs are met comprehensively and in good time (General Medical Council 2006, the Royal College of Psychiatrists 2009 and Nursing and Midwifery Council 2009 Standard and NHS Record Keeping - NHS Code of Practice for Record Keeping 2006; Code of conducts for relevant AHPs as per HCPC).

11.2 All NHS Trusts are required to keep full, accurate and secure records (Data Protection Act 1998) demonstrate public value for money (Auditors Local Evaluation) and manage risks (NHS Litigation Authority, ALE, Information Governance Toolkit, Essential Standards). Compliance with this Policy and these legal and best practice requirements will be evidenced through information input into the electronic record.

11.3 The CRHT Team will keep appropriate integrated clinical Computerised records via the trust electronic record system (RiO) on all service users under the care of the team. All records will adhere to the appropriate standards for record keeping and be in accordance with all appropriate national and professional standards.

11.4 For assessments completed by CRHT full documentation (CORE, Risk assessment, HoNOS, and clustering) is required as a minimum standard.

11.5 All entries are to be entered as soon as possible after service user contact.

11.6 All entries MUST be validated. Where there are staff unable to validate their own notes (student nurses, or health care workers) the shift coordinator or nurse in charge has responsibility for allocating staff to ensure that this happens

12 PHARMACY & MEDICATION MANAGEMENT

12.1 The KMPT medicine management policy and the NMC Guidelines for the administration of medicines inform all issues of prescribing, dispensing, supplying, administering and storing of CRHT medicines. The information in this section should be read in conjunction with the medicines management policy.

12.2 Medication History

12.2.1 A complete list of current medications and allergies/adverse drug reactions (ADRs) will be obtained for all clients under the care of CRHT.

Sources may include:

- GP summary - this can be obtained by contacting the clients GP and this should be uploaded to the RiO documents. Alternatively, this information can also be derived from the patient's Summary Care Record (SCR) or Medical

Interoperability Gateway (MIG) viewer via RiO. Information from these sources should not be uploaded on to the patient's record.

- GP referral letter
- Hospital inpatient chart
- Hospital discharge letter / EDN
- Patient's own medication
- Compliance Aids
- Care home records e.g. Medication Administration Record (MAR) Chart
- Specialist clinics e.g. CMHT, drugs misuse clinics, clozapine clinics,
- The clients community pharmacy

12.2.2 A minimum of two sources of reliable information should ideally be used to carry out the medication history process to ensure the information is as accurate as possible.

12.2.3 Confirmation of how the medication is being taken (this may not match the prescription) should be obtained from the client.

12.2.4 Information regarding over-the-counter medications, medications bought on-line and other non-prescription drugs should be obtained from the client.

12.2.5 All allergies/ADRs and current medications should be recorded on the first section of the CRHT prescription form (see appendix G1). Allergies/ADRs should also be recorded in the allergy section on RIO.

12.2.6 The philosophy of the CRHT Team is that users of the service have a right to access all relevant information about any medication prescribed for them. This information may be provided by a number of routes, including verbal and written communication. Written information is available from the Choice and Medication Website accessible at https://www.choiceandmedication.org/kmpt/

12.3 Patient's Own Drug (POD)

12.3.1 Wherever possible, medicines should be left in a client's home. Storage at the CRHT base should only be done in exceptional cases.

12.3.2 If access to the client's actual medicines container is available at the point of assessment the assessor will request sight of the containers and will ask whether the client has been taking the medicines. This is to include complementary medicines. Staff should also check that the medication is not out of date, and will advise on safe storage. Please refer to the POD suitability assessment tool in appendix G3.

12.3.3 If the client asks CRHT to remove old, out of date or unwanted medication, the **removal/destruction of medication – patient consent form** in appendix G2 should be competed. If the client refuses to surrender out of date or medicines no longer required they must be advised against taking these medicines.

12.3.4 If the client is assessed to be at risk from medicines left in the home, a team member may remove the medicines following agreement from the client, documenting this on the **consent form** in appendix G2. This must be uploaded to clinical documentation on RIO and titled: "**Medication Destruction Consent Form**" and this information added to progress notes. If the client consents to removal but cannot sign the form this should be documented on the form and on RIO.

12.3.5 If overdose is considered likely, there is a duty to remove medicines (if safe to do so) with or without client's permission. Permission (or refusal) must be clearly documented in the client's progress notes, dated and timed, and signed by the team member and client using the process outlined in section 12.2.3. If medication is removed without permission, the reasons for this should be clearly documented and explained, along with the date, time and signature of the team member taking responsibility for its removal. If possible there should be a discussion with the wider MDT on the reasons why the medication needs to be removed. Document this discussion on RiO.

12.3.6 These medicines are the property of the client and should not be destroyed or otherwise disposed of without the agreement of the client or carer.

12.3.7 Medication can be disposed of in accordance with the Trust waste management policy or retuned to the community pharmacy.

12.4 Transportation of Medication

12.4.1 Practitioners are responsible for the safe and appropriate transportation and correct delivery of prescribed medication that they obtain. Once dispensed, medicines are the property of the client, unless they have given permission for the destruction of the medication.

12.4.2 Medicines will be kept out of sight within a secure container, within the locked boot of a car when travelling. It is not necessary to keep medicines in the secure container during a visit i.e. when transferring from the car to the client's residence.

12.4.3 A zippered bag secured with a plastic tag is considered to be a secure container.

12.4.4 Loss or theft of medicines in transit

12.4.5 In the case of medicines dispensed by a community pharmacy on form FP10, or a hospital pharmacy, all of the following should be informed: -

- Client/ carer
- Line Manager
- GP/Dentist or other qualified prescriber who issued the FP10/prescription
- Dispensing Pharmacist (hospital or community).

12.4.6 If theft is suspected, or if the lost medicines may create a risk to the general public, the practitioner, in conjunction with the Line Manager should inform the police at an early stage.

12.5 Supply of Medicines

12.5.1 Medicines can be supplied by a qualified prescriber using an FP10

12.5.2 Any dispensing of medication should be carried out by pharmacy staff (hospital or community)

12.5.3 Staff can assist and support the client in either taking or collecting prescriptions from doctors or chemists.

12.5.4 Staff can only sign prescriptions on behalf of the client if they are known to be in receipt of the appropriate benefit entitling them to free prescriptions.

12.5.5 Over the counter medication such as analgesics, cold remedies, cough mixtures (this list is not exhaustive) cannot be purchased on behalf of the client.

12.6 Administration of Medicines

12.6.1 Prescribers should record all prescriptions that are given to the patient for ongoing administration including any doses changes or initiated medication on section 2 of the CRHT prescription form (see appendix G1).

12.6.2 Medication that is intended to be administered by the CRHT should be recorded on the second page of the CRHT prescription form.

12.6.3 Medication must not be administered from stock by anyone other than a registered mental health nurse. Other staff can only issue named patient supplies for self-administration by service users.

12.6.4 Supervised self-administration of medication should be documented on the CRHT drug recording form

12.6.5 Filling of compliance aids by qualified nurses is permitted as described in the medicines management policy

12.7 Storage of Medicines

12.7.1 In exceptional circumstances where there is "a significant risk of serious accidental or deliberate self-harm" in leaving medication in the clients residence due to excess storage/hoarding of expired products or items no longer prescribed or wanted, and as agreed by the multidisciplinary team as part of the care plan, a member of the team may remove the clients medication (see 12.2.3 and 12.2.4). The medicines should be stored in the medicines cupboard at the team base and remain the client's property. This action should be recorded in the client's notes and the care plan.

12.7.2 Medicines should be kept in the containers in which they were originally dispensed.

12.7.3 A book (stock register) for recording details of medication stored in the cupboard should be kept with the cabinet. It should detail all medication received and issued, and each entry dated and signed. The stock register should be checked every week.

12.7.4 Whenever practical, unused medication should be returned to the medicine cupboard at the team base for overnight and weekend storage. Where this is not possible, medication (except Controlled drugs) may be stored by a crisis team member in a locked cupboard or drawer at home, (not left in the car), or otherwise secured, for a maximum of 72 hours. This should be communicated to another member of the team.

12.7.5 Controlled Drugs must be stored safely in the ward CD cabinet and recorded in their CD register.

12.7.6 The philosophy of the CRHT Team is that service users of the service have a right to access all relevant information about any medication prescribed for them. This information may be provided by a number of routes, including verbal and written communication.

12.7.7 Staff can access medication information via staff zone to this end.

13 SERVICE PROMOTION

13.1 The team provides written information in leaflet form, outlining the service aims and objectives and how it can be contacted.

13.2 The team will make presentations and be involved in education initiatives on the CRHT Team's work to other parts of the CMHT, to other statutory and non-statutory agencies, and to user and carer forums. As well as Kent Police, who will access the CRHT services to perform officer shadowing within the CRHT services.

13.3 The CRHT Team will maintain links with other Crisis Resolution/Home Treatment Teams via personal contact, conferences, the internet, etc to ensure information on 'best practice is shared.

13.4 The CRHT Team will endeavour to disseminate findings from research/audits conducted on the service and other Crisis Teams work.

13.5 The CRHT will receive learning from the Trust wide sources and incidents to be fed down to staff to improve practice and service delivery.

13.6 Where investigations are undertaken the CRHT team members will make themselves available to support the process of learning, within a no blame culture.

14 COMMUNICATION

14.1 KMPT CRHT work with both paper and electronic record IT systems to deliver effective communication between the Crisis teams and other services. CRHT members carry mobile phones at all times to maintain communication with each other and the team base this also ensures timely response to referrals and fidelity to the KMPT lone working policy (see local protocol at CRHT base).

14.2 Exceptions to the 'Duty of Confidentiality' where permission is not required:

- Where the disclosure is required by law (legislation or court order)
- Where the disclosure is in the public interest, for example to protect a member of the public from harm (including carers and families) or to protect the service user themselves; this extends to sharing risk information with the police where risks are high.
- If the service user is incapacitated, information may be passed to their carer if it is in the service user's best interest.
- If child protection issues are present or suspected.

14.3 Where the service user has withheld permission to share information with family/carers, the CRHT Team will respect this decision. Clinicians will record that permission has been withheld and keep this record up to date, so that if the service user later decides that information can be shared with families/carers, the service user will be aware of this.

14.4 When service users have withheld permission to share information, the CRHT Team will provide families/carers with enough relevant information to enable them to provide care effectively and take from carer's relevant collateral history and record this to inform risk management and care decisions.

14.5 Listening to carers and discussing their own experience of caring does not breach confidentiality, nor does providing general information. Where permission has been withheld the CRHT Team will provide carers with such support when appropriate.

15 HEALTH PROMOTION & EDUCATION

15.1 CRHT Team clinicians play an important educational role by providing timely information to service users and family members/carers on the nature of the mental illness, prognosis, treatment options, medication effects and side effects, and service options. Information can be provided during special meetings established for that purpose or be provided over time during regular contact.

15.2 The needs of dependent and adult children in relation to information about their parent's illness must be responded to in a manner which is age appropriate and recognises the fears and misconceptions which may be experienced by children. The CRHT Team will liaise closely with Social Services Children and Families Services wherever appropriate, and will always adhere to statutory responsibilities regarding children and young people.

15.3 Service users and their families/carers must be given frequent opportunities to ask questions and seek clarification; however service users consent to disclosure of information will always be sought and encouraged. In cases where consent has been given, the CRHT Team will ensure that clinicians involved in the service user's treatment know that they can share information with families/carers.

16 TARGETS & OUTCOMES

16.1 The outcome following implementation of this document is as follows:-

- Increased numbers of acutely unwell clients being home treated (choice)
- Increased number of clients for whom early discharge from hospital can be achieved by offering them home treatment.
- A decrease in the Average Length of Stay for clients in the acute wards.
- An increase in 7 day follow-up post discharge from acute wards

17 AUDIT & MONITORING

17.1 Supervision arrangements

- Operational and professional supervision will be provided in line with Kent and Medway Partnership Trust Supervision Policy.
- Clinical, Managerial and Operational leadership will be provided by the Service Manager, Team Manager, and Consultant Psychiatrist(s).

17.2 **Audit and Evaluation**

17.2.1 The effectiveness of the CRHT Team will be continually evaluated and methods of evaluation will include:

g) Clinical Supervision

h) Activity data for the CRHT Team

i) Patient interviews at point of discharge

j) Evaluation of carer satisfaction

k) Key service indicators and clinical audits

l) Staff morale indicators via satisfaction surveys, sickness levels, etc

m) Audit of 'Serious Incidents' via the Trust risk management process

17.2.2 The service will also be evaluated by a series of 'Key Performance Indicators', which will include:

n) Number of referrals

o) Source of referral

p) Number of face to face assessments

q) Response times to referrals

r) Average contacts per home treatment episode

s) No. of visits undertaken jointly

t) Number of people accepted into the service for treatment / episodes

u) Safer Staffing figures

17.2.3 In addition, the wider impact of the CRHT Team on the 'whole system' of mental health services will be evaluated by a series of KPI's including:

v) Number of admissions to Inpatient Units

w) Number of 'emergency re-admissions within 28 days'

x) Figures for bed occupancy

y) Average length of stay (LOS) in Inpatient beds

z) Number of 'acute overspill admissions'

aa) Waiting times for routine assessments (LMHS)

bb) Number of MHA assessments carried out

17.2.4 All CRHT Team clinical records will be subject to regular audit and review in line with Kent and Medway Partnership Trust policy.

17.2.5 All CRHT Team Clinicians will be responsible for carrying out HONOS upon assessment and discharge from the ~CRHT Team (via RIO)

18 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

18.1 All staff will receive regular clinical and management supervision; annual KSF appraisals and undertake compulsory training/updates in line with the Trust policy and procedures.

18.2 The CRHT Team will be committed to providing appropriate training to enable all members of the team to carry out their roles and responsibilities effectively at all times.

18.3 The CRHT Team will ensure networking and best practice by liaising and communication with other CR/HT services, and by participating in 'benchmarking' with other appropriate crisis teams and services.

18.4 All staff will undertake core training as identified by the Acute Care Group. This training will be where practicable joint with inpatient care staff as to promote the acute care identity. Core training will cover the following areas:

- Clinical Risk Assessment
- Dual Diagnosis
- Psychosis workshop
- Recovery Coaching
- Person Centred Care Planning
- Suicide Prevention
- Discharge Planning

18.5 Training and development within acute teams will focus on engagement with people; developing person centred, outcome orientated recovery goals with a focus on psychological formulations; and skills around closure and safe transfer of people to other services.

18.6 Champions will be developed within the service. These champions will provide the immediate and ongoing support and supervision of team members. Champions will have additional skill e.g. non medical prescriber, AMHP. They will themselves receive support and supervision from psychological practitioners and or other senior clinicians within the service line.

18.7 There will be an expansion of the champion's to cover external agencies, such as Kent Police.

18.8 Staff will be expected to develop reflective practice and will consider the impact on transitions for people, stigma and expectations of all parties.

18.9 Additional training must be aimed at solution focused.

19 STAKEHOLDER, CARER AND USER INVOLVEMENT

19.1 Stakeholders will be informed of the document/any changes via The Acute Forum represented by The Associate Director of Acute Services.

19.2 Stakeholders will be asked for input on policies that need joint agreement or will have joint input.

20 EQUALITY IMPACT ASSESSMENT SUMMARY

20.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

21 HUMAN RIGHTS

21.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that requirements of the Human Rights Act are properly upheld.

22 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

See section 16 & 17

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non compliance
Service Response - time frames; outcome of referrals etc	Review referrals for quality and appropriateness of response (timeframe & outcome)	Service Manager; Directorate team	Monthly report /feedback from each team	Quarterly report on activity KPI Sharing of best practice	
Appropriateness of referrals	Review referrals for quality and appropriateness of referral	Service Manager;	Monthly report /feedback from each team	Quarterly report on activity KPI Sharing of best practice	
Effectiveness of service	Data monitoring; outcome measures such as HONOS;	Service Manager; Directorate team	Monthly report /feedback from each team	Quarterly report KPI Supervision Sharing of best practice	
Service satisfaction	Patient interviews at point of discharge/transfer User/carer satisfaction survey	Service Manager PALS Directorate team	Quarterly report	HONOS; Patient survey Report to Directorate team	
Staff morale	Supervision Staff survey Sickness absence monitoring Retention and recruitment monitoring	Service Manager HR Directorate team	Quarterly report Feedback from each team	Supervision Staff survey Sickness absence report HR report	
Impact on wider MH pathway	Data monitoring (no admissions; MHA assessments; LOS; DTC; etc)	Service manager; Directorate team	Monthly report /feedback	Quarterly report KPI	
That policy is reviewed in line with national or local changes	New legislation or local Requirements from DOH, CQC, NICE, are regularly sourced for impact on Trust policy	Acute Service Line	Annual Policy review date or as required by national drivers	Actively review and make changes to policy	

23 EXCEPTIONS

23.1 The Policy will not apply to those referrals who do not meet the eligibility criteria.

23.2 However, advice or signposting would be considered and offered.

APPENDIX A ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning	Abbreviation	Meaning
A&E	Accident & Emergency	KCC	Kent County Council
AMPH	Approved Mental Health Professional	KMPT	Kent and Medway Partnership Trust
		LOS	Length of Stay
CMHT	Community Mental Health Team	MHA	Mental Health Act
CMHTOP	Community Mental Health Team for Older People	MHLD	Mental Health of Learning disability
CPA	Care Programme Approach	OT	Occupational Therapist
CRHT	Crisis Resolution Home Treatment	OOH	Out of Hours Service (Social Services)
DTC	Delayed Transfer of Care	PCTs	Primary Care Trusts
ECS	Enablement & Co-ordination Services	PwLD	People with Learning Disability
ED	Emergency Department	SECAmb	South East Coastal Ambulance
EDS	Early Discharge Plan	SHO	Senior House Officer
FRIS	First Response and intervention Services	S136	Section 136 (Mental Health Act)
GPs	General Practitioners		
HONOS	Health of the Nation Outcome Score		

APPENDIX B PERSONS/GROUPS INVOLVED IN THE DEVELOPMENT AND APPROVAL OF THIS DOCUMENT

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CRHT Steering Group
Acute Service Line Governance Meeting

Review Completed By:

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Consultation From:

All band 7 & 8 staff across the service line
Director & Assistant Directors

Ratified Via:

Acute Service Line Governance Meeting

2019 Reviewed by:

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Ratified via:

Acute Care Group (virtual)

APPENDIX C CRHT TEAM CORE INFORMATION

North East Kent CRHT
24 hours/7day a week service

Address
St Martin's Hospital, Littlebourne Road, Canterbury, CT1 1TD

General enquiries: 01227 812033
Referral direct line: 01227 812286

Webpage:
https://www.kmpt.nhs.uk/our-services/north-east-kent-crisis-resolution-and-home-treatment-team/

South East Kent CRHT
24 hours/7day a week service

Address

St Martin's Hospital, Littlebourne Road, Canterbury, CT1 1TD

General enquiries: 01227 812211
Referral direct line: 01227 812215

Webpage:
https://www.kmpt.nhs.uk/our-services/south-east-kent-crisis-resolution-and-home-treatment-team/

West Kent CRHT
24 hours/7day a week service

Address
Priority House Hermitage Lane Maidstone ME16 9PH

Tel: 01622 725000

Webpage:
https://www.kmpt.nhs.uk/our-services/west-kent-crisis-resolution-and-home-treatment-team/

Medway and Swale CRHT
24 hours/7day a week service

Address
A Block, Medway Maritime Hospital Gillingham, ME7 5NY

Tel: 01634 968460

Webpage:
https://www.kmpt.nhs.uk/our-services/medway-and-swale-crisis-resolution-and-home-treatment-team/

North Kent CRHT (DGS)
24 hours/7day a week service

Address
Littlebrook Hospital, Bow Arrow Lane, Dartford, DA2 6PB

Tel: 01322 622129

Webpage:
https://www.kmpt.nhs.uk/our-services/dartford-crisis-resolution-and-home-treatment-team/

APPENDIX D1 CLINICAL INDICATORS – PATIENT FLOW

Clinical Indicators for Acute Care and Admission for KMPT Inpatient services

Acute in patient care should be considered for people with difficulties arising from and as a consequence of mental disorder whose needs are greater than can be provided by community mental health teams. There must be an expectation that inpatient care will offer benefit and will not contribute to escalation of risk or deterioration in mental health.
Acute care sits within a wider pathway that has a recovery ethos. Inpatient stays should support the establishment and maintenance of community links and should be for the minimum time necessary.

Crisis resolution and Home Treatment teams provide the same care and interventions as an inpatient ward and are for patients who despite having acute care needs can be managed in the community. The below criteria (apart from the criteria related to the detention under the MHA 1983 (amended 2007)) apply to CRHT.

1. **Essential indicators**

The following criteria **must** be met:

- Patients have mental disorder.
- Expectation of benefit from acute care (and specifically admission if requested by referrer) adhering to the eligibility criteria documented in RIO with a proposed inpatient specific treatment or care plan.

2. **Additional Clinical indicators for care...**

A minimum of one of the following should apply

I. *Self-Harm/Suicidal ideation* - Immediate risk of suicide or serious self-harm as a result of acute mental disorder that cannot be managed without acute service intervention. Risk should represent change in presentation and not be a manifestation of chronic risk and ongoing behaviour consistent with diagnosis. There should be an expectation acute intervention will diminish risk and should not increase risk. If interventions that will reduce risk or enable improvement in condition are not available on an acute ward admission is unlikely to be helpful and should be avoided. If chronic risk will not be alleviated or could be increased by acute intervention admission should be avoided. If there is a risk of establishing chronicity and therefore escalating risk admission should be avoided.

II. *Dangerous Behaviour* – Risk to others as a consequence of mental disorder that represents a change in presentation and is a result of acute change in mental state. Inpatient care should not be considered if it is thought admission will either fail to diminish risk or increase risk or if no interventions that will reduce risk or enable improvement in condition are available on an acute ward. Acute admission is for the purpose of treatment and should not be considered as a custodial option to manage risk to others.

III. *Self-Neglect* – Impaired ability to maintain basic self-care as a result of acute presentation of mental illness that cannot be managed in the community with appropriate enhanced support. Poor self-care arising from a chronic condition or physical health concerns should be managed in appropriate settings which are unlikely to be an acute psychiatric ward.

IV. *Nutritional Deficiency* – Poor food or fluid intake due to acute mental illness that requires 24 hour supervision to maintain safe nutrition or hydration. A patient for whom there is concern physical health is compromised to the extent hospital care is required to preserve life need medical intervention not available on an acute psychiatric ward and should be referred to specialist physicians. If admission is required for physical health reasons it should be to a general hospital. The resource, expertise and competencies required for safe management are not available or deliverable on an acute psychiatric ward and the primary acute need is medical. Acute psychiatric wards do not provide specialist eating disorder interventions. If such is required specialist referral is necessary. Acute care is not a safe alternative or interim measure.

V. *Diagnostic Assessment* – Admission is required to provide in-depth assessment to establish clarity about the nature and intensity of mental disorder or diagnosis and its impact on recovery and **this cannot be achieved in a community setting safely.**

VI. S*pecific interventions* that cannot be safely introduced in the community such as ECT or medication initiation requiring monitoring not possible in the community.

VII. *Detention under the Mental Health Act* should meet the above criteria.

3. Patients likely not to benefit from an acute inpatient care are those being referred for:

- Crisis intervention in the absence of mental disorder or where the mental disorder is chronic and presentation unchanged.
- Admission may increase chronic risk.
- Expectation of substantial transitional escalation in risk during the post discharge period.
- Provision of a “safe place” during life crisis in the absence of a mental disorder.
- Provision of a “safe place” if there is a risk acute admission will become incorporated into the patient’s repertoire of coping strategies in such a way that the future or immediate risk of behaviour dangerous to self or others is increased.
- Risk management in the absence of a mental disorder.
- Drug and alcohol related crises in the absence of treatable mental illness.
- Emotional crises that are explained by normal human experience.
- Changes in social or personal circumstances.
- Unavailability of specialist placements such as rehabilitation or tier 4 personality disorder services.
- Safeguarding issues not arising from or amenable to treatment of mental disorder.
- Patients whose need is chronic and for whom risk and presentation has not changed.
- Patients where the care pathway is not available within an acute mental health service.
- Carer or placement breakdown in the absence of acute mental health episode.

Patients must not be told they will have an admission to these services until the referral process is completed and alternatives to admission have been fully considered and excluded.
Patients should be told admission will be considered but that there will be a joint decision making process in relation to whether an admission may benefit their individual needs.

4. **Process for admission to CRHT or to inpatient services is as follows:**

Referrals to CRHT should identify individual patient needs that cannot be met in a community setting and should include:

- Identified acute metal disorder and provisional diagnosis.
- Barriers to the provision of community care.
- Expectation of acute intervention or admission and what it should achieve in terms of alleviating symptoms and impact of the disorder on the patient.
- Objectives that should be met in order that the patient can return to community.
- Pre-known factors that may present barriers to returning to the community. This includes family/relationship/placement breakdown that may result in the patient becoming homeless and the plan in place for addressing these.

CRHT will determine whether they can provide care in the patient's home. If this is not possible they will refer to the Patient flow team.

Provision of required information is the responsibility of the referrer.

Failure to provide it does not allow CRHT to make an informed decision about appropriate intervention and care and may lead to a bed not being offered to someone who needs it.

5. **Patient Flow Team (PFT):**

CRHT will discuss admission with the PFT. The expectation will be that the team are provided by the referrer with a rationale for admission that explains

- The need for admission
- Plan for the admission that they have agreed with the community team if this referral originated outside of the CRHT.

Any specific patient needs (e.g. HDU bed, enhanced observation levels, physical or family needs) should be identified to help the PFT allocate the most appropriate inpatient environment.
The PFT will allocate a bed and inform the ward. The referrer must liaise directly with the ward to agree the time of admission and immediate treatment objectives.

6. **Old Age Wards**

Some patients will benefit from an admission to an older adult ward. The following is guidance to support the decision to access older adult service expertise, which should not be based solely on the age of the patient:

- A primary diagnosis of dementia
- People with significant physical illness or frailty that contributes to, or complicates, the management of their mental illness. This may include people under the age of 65 on occasions
- People with significant psychological or social difficulties associated with ageing, or end of life issues, who feel their needs may be best met by an older people's service. This would normally be people over 70 years of age.

7. **For Patients with Dementia:**

Dementia is a progressive condition. At least half of dementia sufferers will experience psychiatric symptoms in the course of their illness. It is important to note that in the latter stages of dementia, moving a person can cause a very swift downward progression; and may hasten mortality.

Patients with behavioural symptoms in dementia would be unlikely to benefit from an admission where inpatient care is simply providing a 'holding solution' as an alternative to a more timely managed transition to a more appropriate care environment, which may more appropriately include drawing on other resources such as overnight crisis carers, etc.

Acute psychiatric admission in dementia sufferers is often considered for the following reasons:

- For psychiatric assessment in order to ascertain the diagnosis, often in the context of a significant or sudden change in presentation associated with a significant degree of risk to self or others
- Behavioural and psychiatric symptoms of dementia, associated with a significant degree of risk; which is deemed to require a period of treatment, or is considered modifiable with psychiatric treatment
- Co-morbid mental illness which is deemed to require a period of acute psychiatric assessment and treatment

1. Where possible, physical health causes for the patient's presentation should be ruled out/treated first.

2. It is important to consider whether there could be a role for the crisis team. Patients in the milder stages of dementia with psychiatric symptoms could be considered for crisis home treatment.

3. Community Services may consider alternatives to admissions of patients with BPSD where available. This should include care packages for those still living at home; as well as social services that could provide suitable interventions such as day care centres or offer a sitting/carer support service. Consider dementia crisis interventions where available.

4. Acute admission for dangerousness in dementia due to severe aggression should only be considered where there is inadequate understanding of the patient's needs in order to affect a swift local resolution and transfer to a more appropriate community, long-term care setting. There would be an ongoing, imminent risk of significant violence to others and no clear need for acute general hospital treatment.

Although CRHT may not be appropriate, the patient flow team will need to gate keep the admission and allocate a bed where required in the most suitable environment for the patient based on their individual needs.

Clinical indicators – Factors to consider when admitting patients with known or suspected alcohol misuse to an Acute Mental Health ward.

People who are mis-using substances often have social issues related to this issue these can include, Homelessness, Criminal justice issues , relationship breakdowns and financial issues , which can cause a great deal of emotional distress, for the individual.

Substance misuse is not an acute mental illness but a condition that needs specialist care from the specialist services, which can not only offer the correct the physical and psychological care, but also have very clear and efficient pathways that can support patients with their social needs. Acute mental health units and wards do not have the expertise of specialist services so are not able to offer the appropriate care to people whose main issue is substance misuse.

In order to make sure the person being assessed is on the right pathway for them it is important to consider whether the emotional distress is a by-product of the abuse and social factors that have arisen as a result of this abuse or whether there are other symptoms that would suggest an acute mental illness.

However sometimes patients will have an acute mental health illness or a primary diagnosis in relation to their mental health needs, in these cases it may well be appropriate for mental health services to be involved in the treatment but the AMHUs may not be the safest place for someone to be admitted to if they have a high level of physical dependency on alcohol.

In order to as sit clinical staff assessing people with Alcohol misuse the below lays out the assessments and factors that should be taken into account in relation to whether it is appropriate to admit someone with a clear mental illness and a need for an alcohol detox.

Clinical staff referring for an Acute Mental Health admission for someone with a clear acute mental illness and alcohol dependency should have considered the following:

<u>Assessment of a patient with alcohol dependency</u>

- **Acute Alcohol Withdrawal**

SYMPTOMS:

1) Signs & symptoms of autonomic over-arousal:
   - Sweating
   - Tachycardia (>100/min)
   - Raised BP
   - Fever (37-38^{o} C)
   - Hyper-reflexia
2) Characteristic tremor, starting in the hands but progressing to the head and trunk as the severity worsens
3) Anxiety, restlessness, irritability, depression, headache, insomnia and tiredness
4) Anorexia, nausea and weakness
5) Confusion
6) Seizures, hallucinations, delirium and Wernicke's encephalopathy
7) Hyperpyrexia, ketoacidosis, and profound circulatory collapse may also develop.

- **ASSESSMENT OF ALCOHOL WITHDRAWAL:**

All patients admitted to wards should be asked about alcohol intake. There is no reliable laboratory marker for this. AUDIT or CAGE should be considered when history elicits suspicion of alcohol misuse.

- The Alcohol Use Disorders Identification Test (***AUDIT***) is the most appropriate means of identification of alcohol misusers in general hospitals).The minimum score (non-drinkers) is zero and the maximum possible score is 40. A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption
- The ***CAGE*** questionnaire is used as a quick alternative; however this can only pick up the most severe alcohol misuse. A score of 2 or more is indicative of this.
- **Detailed alcohol history should include:**
    - Quantity
    - Frequency of use
    - Highest intake
    - Previous treatment; previous abstinence; previous symptoms experienced during
    - withdrawal
    - Triggers for drinking
    - Psychiatric problems
    - Motivation
- **Risk factors for progression to severe withdrawal include:**
    - High alcohol intake (>15 units per day)
    - Previous history of severe withdrawal, seizures or DTs
    - Concomitant use of other psychotropic drugs
    - Poor physical health
    - High levels of anxiety or other psychiatric disorders
    - Electrolyte disturbance
    - Fever or sweating
    - Insomnia
    - Tachycardia

- **Investigations**

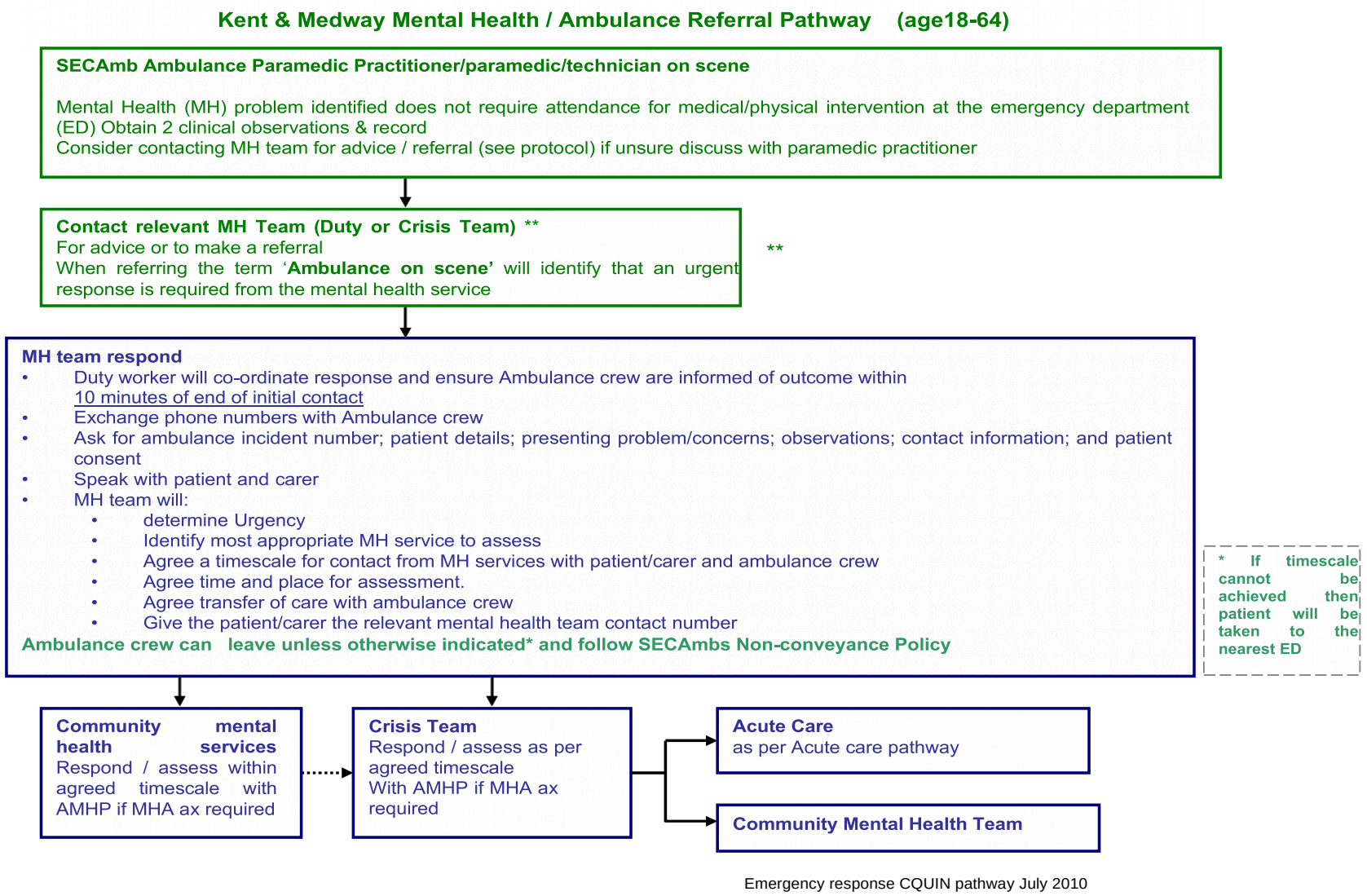
➢ Basic investigations should include FBC and U&E and LFT magnesium and phosphate and glucose.
➢ Consider INR if abnormal LFT.
➢ Consider Urine drug screen and blood alcohol level if diagnosis unclear.

Referral to the acute hospital should be considered if a patient meets one or more of the following criteria:

- CIWA-Ar score >10
- Signs of Wernicke's encephalopathy (WE) (e.g. confusion, ataxia, nystagmus, ophthalmoplegia, neuropathy)
- Patient confused or has hallucinations
- Patient has epilepsy or history of fits
- Patient undernourished
- Severe vomiting or diarrhoea
- Uncontrollable withdrawal symptoms
- Acute physical illness
- Multiple substance misuse
- Previous complicated withdrawal
- Pregnancy
- Co-morbidities

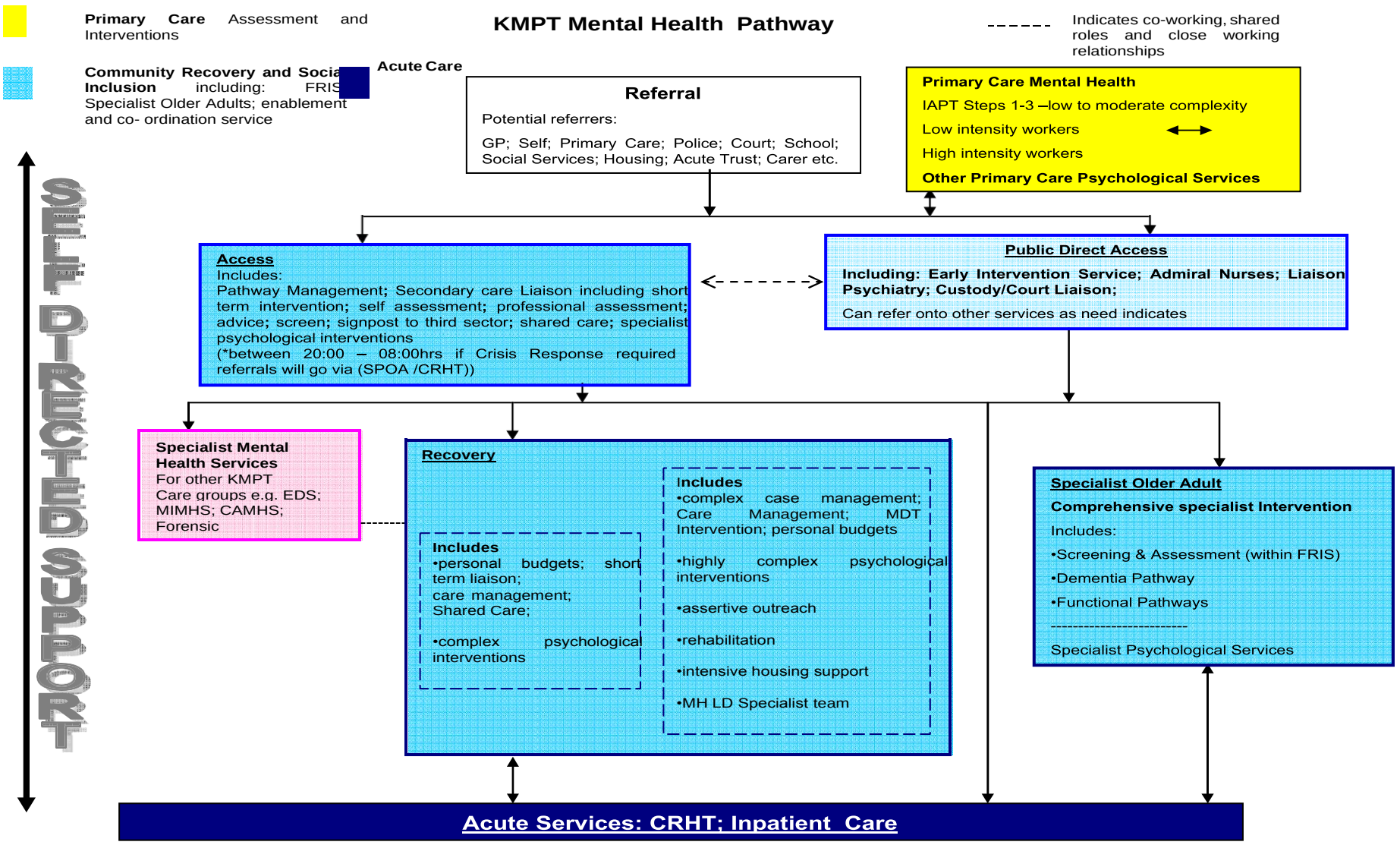
Consider a lower threshold for inpatient assisted withdrawal in vulnerable groups, for example, homeless and older people.

APPENDIX D2 TREAT & REFER PATHWAY



Emergency response CQUIN pathway July 2010

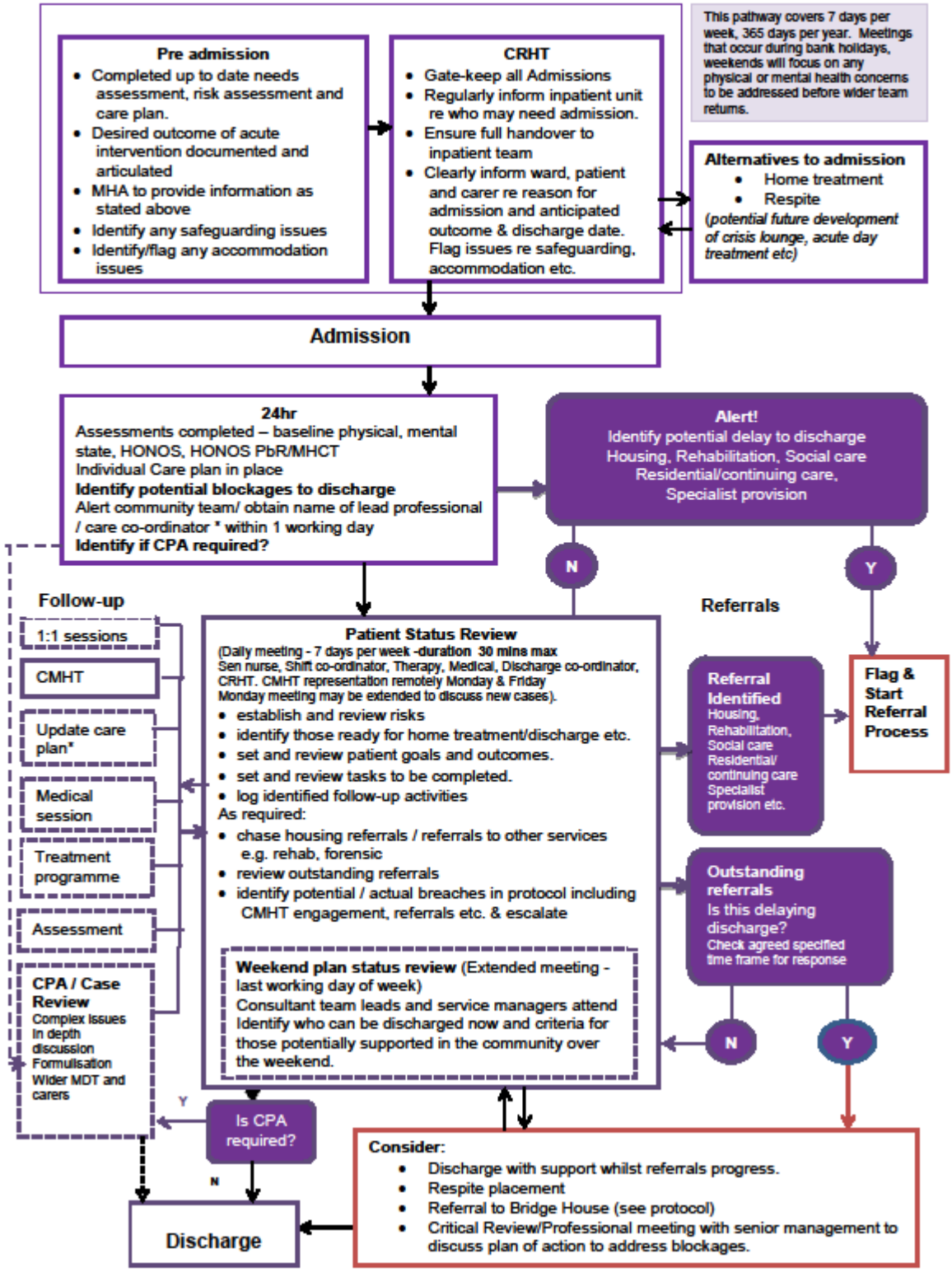
APPENDIX D3 KMPT MENTAL HEALTH PATHWAY



OSG: November 09

APPENDIX D4 **ACUTE CARE: PATIENT FLOW: FEB 2015**

Acute Care: Patient Flow: Feb 2015



APPENDIX E – ACUTE SCREENING TOOL

RiO

Referral Screening

Form completed by

Surname:
Forename:
Job Title:
Date / Time:

Regarding Client / Client

Surname:
Forename:
DOB:
NHS Number:

In RiO link to referral by clicking on magnifying glass (this form can only be linked to a referral once and represents the situation at that point in time)

Client Type*

Please select:
- Dual sensory loss
- Dementia
- Physical disability
- Hearing Impairment
- Learning disability
- Substance misuse
- Visual Impairment
- Mental health
- Other vulnerable people

Reason for referral

Planned outcome

Result of screening

Please select:

- Accepted for immediate action
- Accepted and placed on app waiting list
- Service request passed back to referrer
- Service request passed to another agency
- Patient declined to be treated
- Patient Died

Details of result

Does client agree to the referral? Y / N

Perceived or reported risk

Perceived risk to staff

Current treatment

Access Issues including problems entering the premises

What has been done so far by the referrer?

What is wanted from our service?

APPENDIX F CRHT CLOSURE SUMMARY

CRISIS RESOLUTION & HOME TREATMENT TEAM
CLOSURE SUMMARY

FRIS/ Enablement/ co-ordination Team……

GP:

Dr «Registered-GP»
«Ext-Address1»
«Ext-Address2»
«Ext-Town»
«Ext-City»
«Ext-Postcode»

Tel:

Your Care Co-ordinator/ Lead Professional IS:-

Client: «Title» «Forename» «Surname» DOB:«Date-of-Birth» NHS No: «NHS-Number» «Full-Address» Tel No:

The above named was assessed on …… and has now been Discharged from CRHTT on …….

FORMULATION OF HOME TREATMENT INCLUDING RISK ON CLOSURE:-

CRHT CLOSURE Medication - State All

Medicine	Dose & Frequency	Days Supplied	GP to cont Yes/No	OPD to cont Yes/No

FOLLOW UP RECOMMENDATIONS:-

Closure Summary copied to other (Specify)……..

Written by:- .Designation:- .Date:- ….
Signature:-…….

Copy of Risk Assessment to Care Co-ordinator / Lead Professional in ALL Cases

APPENDIX G1 – CRISIS RESOLUTION AND HOME TREATMENT (CRHT) MEDICATION CHART

NAME…….. **D.O.B**……
ASSESSMENT DATE……
NAME OF ASSESSOR ……

SMOKER – Y/N

ALLERGIES/ADVERSE DRUG REACTIONS:

(IS THIS DOCUMENTED ON RIO? – Y/N)

LIST OF CURRENT MEDICATION ON ASSESSMENT – *Include physical and psychotropic medication also OTC (Over the Counter) Herbal remedies*

GP ENCOUNTER REPORT REQUESTED? – Y/N ***SCR/MIG ACCESSED? – Y/N***

Section 1

DATE STARTED	MEDICATION & OTC/ HERBAL	DOSE & FREQUENCY	INDICATION	GP OR CRHT INITIATED?	DATE STOPPED LEAVE BLANK IF MED IS TO CONTINUE	QTY

MEDICATION PRESCRIBED DURING HOME TREATMENT – *Include all changes*

Section 2

DATE STARTED	MEDICATION	DOSE & FREQUENCY	INDICATION	PRESCRIBER SIGNATURE	FP10 ISSUED OR USING PATIENT OWN STOCK	DATE STOPPED (LEAVE BLANK IF MED IS TO CONTINUE)	QTY

PATIENT NAME: **D.O.B:**

MEDICATION TO BE	RING THE		WEEK 1 (RECORD DATE UNDER THE DAYS BELOW)	WEEK 2 (RECORD DATE UNDER THE DAYS BELOW)

ADMINISTERED BY CRHT TEAM			BOXES – ADD EXTRA TIMES IF NEEDED	VARIABLE DOSES	MO	TU	WE	TH	FR	SA	SU	MO	TU	WE	TH	FR	SA	SU
DRUG		DOSE	BFAST															
			LUNCH															
ROUTE	PRESCRIBER SIG.	FREQUENCY																
			TEATIME															
START DATE	STOP DATE	STOPPED BY	BED															
			ADDITIONAL INSTRUCTIONS															
DRUG		DOSE	BFAST															
			LUNCH															
ROUTE	PRESCRIBER SIG.	FREQUENCY																
			TEATIME															
START DATE	STOP DATE	STOPPED BY	BED															
			ADDITIONAL INSTRUCTIONS															
DRUG		DOSE	BFAST															
			LUNCH															
ROUTE	PRESCRIBER SIG.	FREQUENCY																
			TEATIME															
START DATE	STOP DATE	STOPPED BY	BED															
			ADDITIONAL INSTRUCTIONS															
DRUG		DOSE	BFAST															
			LUNCH															
ROUTE	PRESCRIBER SIG.	FREQUENCY																
			TEATIME															
START DATE	STOP DATE	STOPPED BY	BED															
			ADDITIONAL INSTRUCTIONS															
DRUG		DOSE	BFAST															
			LUNCH															
ROUTE	PRESCRIBER SIG.	FREQUENCY																
			TEATIME															
START DATE	STOP DATE	STOPPED BY	BED															
			ADDITIONAL INSTRUCTIONS															

ADMINSTRATION AND OMISSION CODES; N=No Drug Available SA = Self Administered (Supervised) R = Refused S=Sleeping G= given & supervised administration O=Omitted (other reason, which must be recorded in the patients notes)

APPENDIX G2 REMOVAL/DESTRUCTION OF MEDICATION – PATIENT CONSENT FORM

NAME:	
ADDRESS:	

NAME OF MEDICATION	STRENGTH	FORM (E.G. TABLETS, CAPSULES)	QUANTITY

Please circle the appropriate answer for the questions below

I consent to the removal of the medication listed above* – YES/NO
I consent to the destruction of the medication listed above* – YES/NO

For inpatients - refer to the Patient's Own Medication form completed on admission

Please print name, sign and date

Name		**Signature**		**Date**	

Staff member to print name, sign and date to confirm that medication has been removed:

Name		**Signature**		**Date**	

- **If medication is to be destroyed, it should be done as soon as possible and stored safely in a medication cupboard in the interim. Controlled Drugs (CDs) must be placed in a ward CD cupboard and recorded in their CD register. Please contact your local pharmacy team only if CDs are to be destroyed.**
- **If patient does not consent to the removal and destruction of medication but there has been a change/discontinuation or the medication is no longer appropriate for use, have a discussion with patient and if possible, the wider MDT on the reasons why the medication needs to be removed and destroyed. Document this discussion on RiO.**
- **Team to follow the safe and secure handling of medicines in the community when transporting and storing medication.**

The above medications were appropriately disposed of on ……../……../…….. by……..

ASSESSING THE SUITABILITY OF PATIENT'S OWN DRUG(S) FOR RE-USE

The assessment may be performed by doctors, pharmacists, nurses or pharmacy technicians

Please consider the following:

Yes	Prescribed by the GP or bought over the counter?	**No**	DO NOT USE
Yes	Are the medicines in the original dispensed packaging?	**No**	DO NOT USE
Yes	Are the contents easily identifiable if in a container?	**No**	DO NOT USE
Yes	Label, container and medicine are in an acceptable condition?	**No**	DO NOT USE
Yes	Within expiry date or 28 days of date opened? e.g. Eye drops/liquids	**No**	DO NOT USE
Yes	Patient's name on the label is for the correct patient?	**No**	DO NOT USE
Yes	Drug name. form and strength on the label agrees with contents?	**No**	DO NOT USE
Yes	Can be confirmed medicine has been stored appropriately e.g. refrigerated medicines	**No**	DO NOT USE

MEDICATION IS SAFE TO USE

APPENDIX H – PERFECT WEEK PROCESS GUIDE

Referral/Discharge Process

Care Coordinator / Duty Worker (Locality CMHT Only) must see patient on day of referral.

CMHT senior must screen case to see what other options could be put in place before CRHT referral i.e. increased CMHT input, urgent Dr. Review.

All paper (Core Ax + Risk Ax) must be completed to reflect the current presentation of the patient before referral will be accepted by CRHT.

Once CRHT have accepted the referral (Which can be screened) they will be placed onto CRHT boards and booked in to the diary for a Home visit to commence. First visit should be a registered member of staff to put treatment plan in place.

Home treatment is carried out in the normal fashion.

Once patient has improved and identified for transfer (i.e. Regraded to Green) discharge paperwork should be completed that day and patient told that they are being transferred to CMHT. This transfer will be facilitated at the next conference call. Alternatively, we can transfer on the conference call in the AM prior to a visit that day when patient can be told about transfer to CMHT.

J/V's are not necessary for every person being transferred to CMHT however complex cases and people who are not previously known to services it will be.

Daily Conference call

There is a daily conference call between CRHT and all locality CMHT's that they cover. This allows CMHT the opportunity to identify who the CMHT might refer to CRHT that day and to inform CMHT who is being transferred back to them that will need 7 day follow up. It is also a chance to discuss other issues that have arisen since the last call.

Admission

There is no change to the referral process for admission. CRHT still need to review the need for admission on all referrals from CMHT.

APPENDIX I - CRHT DISCHARGE ACTION PLAN

To be completed at the time of transfer for all clients			**Date of next appointment**:
Client's name:	**DoB:**	**NHS No:**	**GP**
Presenting problems including risks at time of referral.	**Strategies agreed with service user** (*Include carer when appropriate*) **to manage problems**:		**Medication** (*please print*) **dosage, frequency and mode of administration**:
Emergency 24 hour contact			
Completed by: (*Name, profession and signature*)			Date:
Service User signature:			Date