DRAFT CRISIS RESOLUTION AND HOME TREATMENT TEAM OPERATIONAL POLICY

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The latest approved version of this document is online.
If the review date has passed, please contact the Author for advice.

Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	Sep 2024
2	Summarise any change / additions etc. including "no change required" if that is the case	

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Team Lead, Crisis Resolution Home Treatment Teams (North Powys)
Team Lead, Crisis Resolution Home Treatment Teams (South Powys)

Circulated to the following for Consultation

Date	Role / Designation
00/08/2024	Community Mental Health Teams
00/08/2024	Crisis Resolution Home Treatment Teams
00/08/2024	Social Services / Approved Mental Health Professionals Group
12/09/2024	Clinical Policy Advisory Group

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? National Service Framework for Mental Health (1999) NHS Plan (2000) Getting Medicines Right 2 (2010) Mental Health Crisis Care Concordat (2014) NICE: Service User Experience in Adult Mental Health; Improving the Experience of Care for People Using Adult NHS Mental Health Services (2011) Mental Health Act 1983 revised (2007) Social Services and Wellbeing Act (2014) Mental Capacity Act (2005)

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement**
Age			x		Please remember policy documents are published to both the **intranet** and **internet.** The version on the internet must be translated to Welsh.
Disability				x	
Gender	x				
Race	x				
Religion/ Belief	x				
Sexual Orientation	x				
Welsh Language	x				
Human Rights	x				

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document?
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document?
Have you identified any training and / or resource implications as a result of implementing this?

1 – POLICY STATEMENT / INTRODUCTION

Powys Teaching Health Board aims to provide a Crisis Resolution Home Treatment Team (CRHTT) service in the safest and least restrictive environment for the adult population of Powys, i.e. those over 18 years of age. The focus of the service is primarily for those with an acute mental health crisis of such severity that without the involvement of the service they would require hospitalisation.

All interventions provided by the service are short-term, usually for a period not exceeding 6 to 8 weeks, focused on the safety, well-being and empowerment of the individual. Appropriate assessment and evidence-based practice will be utilised, with the aim to meet the individuals needs in a culturally sensitive manner. The service will encourage patients, their family and carers to participate in the development of person-centred Care Plans during the period of crisis. The purpose of all interventions is to maximise autonomy.

The CRHTT service aims to provide safe, effective, home-based intensive treatment in the least restrictive environment, the team is committed to providing rapid response and timely resolution of the crisis.

The underlying philosophy is that the acute mental health care can be provided without recourse to hospital admission. The service is therefore designed to offer a proactive alternative to hospital admission, whilst recognising that in some circumstance's admission to hospital may be necessary in an individual's care.

2 – AIMS AND OBJECTIVES

The service aims to provide home-based treatment to individuals who, in the acute phase of mental health difficulties, would be at risk of hospitalisation in the absence of the team's intervention.

The CRHTT will:

- Act as a gateway to Mental Health in-patient services; rapidly assess every individual where admission is being considered within CRHTT hours. Consider viable alternatives to hospital admission.

- Assess all individuals admitted to hospital outside of CRHTT hours and within 24 hours, to consider viable alternatives to remaining in hospital.

- Provide short-term intensive home- and community-based interventions during the acute phase of mental health crisis.

- All Mental Health Act assessments should first be discussed with the relevant CRHTT.

- CRHTT will attend Mental Health Act Assessments appropriate to criteria whilst accepting "Trusted Assessment" processes and the need to minimise delay to ensure that the right approach to safety, treatment and management is adopted. The CRHTT should not delay a MHA assessment because they are unable to attend in a timely way.

- Provide access to in-patient care when treatment at home is not appropriate.

- The CRHTT service is intended to complement and work in partnership with existing primary and secondary care service providers and will actively communicate their involvement as appropriate. Continuity of care is beneficial to patients and their families and supports discharge from CRHTT.

2.1 – If Admission is Needed

The CRHTT will:

- Firstly, contact the local Hospitals, (Redwoods, Shrewsbury, Felindre Ward and Ward F, Neath Port Talbot or for older adults Redwoods, Clywedog and Tawe ward), NHS beds in surrounding Health Boards, then, if necessary the private sector.

- Identify and commission acute in-patient bed within CRHTT hours. After hours it will become the responsibility of Felindre Ward or, if the ward does not have the capacity, the on-call Manager.

- Ensure the patient is seen by a psychiatrist before or on admission to carry out the admission process.

- Arrange safe and appropriate transport.

- Ensure that early communication with Powys County Council AMHPs is undertaken to enable planning of the assessment should MHAA be required.

- Remain involved with the patient until the crisis has resolved, and they are linked into ongoing care if required.

- Minimise the length of hospital admission by facilitating early discharge with active involvement in discharge planning alongside the patient, family and carer and provision of intensive home treatment.

- Where referrals are not appropriate for home treatment, the service will guide and advise individuals on where to access the appropriate service to meet their needs. The outcome of this will be clearly communicated to the referrer and the individual's GP.

2.2 – Use of Crisis Beds

Felindre Ward has two crisis beds that can be accessed in times of a mental health crisis. These beds are for short term use (e.g. overnight) and patients are assessed at the time of the crisis to determine if this is the best option for them. A further assessment of the need is then made the following day to ensure that the most appropriate care pathway is captured and actioned for them. See Felindre Crisis Beds Policy for more detail **(Appendix 1).**

In the absence of a locally sourced inpatient bed or out of area commissioned bed, consideration should be given to use of the crisis bed in Felindre Ward overnight with CRHTT retaining the responsibility to find a substantive bed the next day.

3 – DEFINITIONS

AMHP	Approved Mental Health Professional
ABUHB	Aneurin Bevan University Health Board
CAMHS	Children and Adolescent Mental Health Service
CMHT	Community Mental Health Teams
CTP	Care and Treatment Plan
DGH	District General Hospital
EDT	Emergency Duty Team
GP	General Practitioner
HCSW	Health Care Support Worker
HTT	Home Treatment Team
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
MHM	Mental Health Measure
MIP	Myrddin in Powys
MIU	Minor Injuries Unit
OOH	Out of Hours
PCC	Powys County Council
PTHB	Powys Teaching Health Board

RC	Responsible Clinician
REP	Risk Enablement Panel
S136	Section 136
WARRN	Welsh Applied Risk Research Network
WCCIS	Welsh Community Care Information System

4 - RESPONSIBILITIES

4.1 – Responsibilities

If patient is living outside Powys but with a Powys GP

The CRHTT work with adults over aged 18 with a GP within the designated catchment area of Powys. This may mean working with patients living outside Powys because they have a Powys GP. If this requires considerable extra travel, or where other Mental Health Services, such as CMHT support are provided by a neighbouring authority, the CRHTT will negotiate which CRHTT will be responsible for providing support in the best interests of the patient.

If patient is living in Powys with an English GP

If a patient is living in Powys with an English GP, the CRHTT should contact the relevant English CRHTT to ask if they wish to provide the service. Should they not agree to do this, the Powys CRHTT will offer the service but contact the commissioning team to make them aware that the service should be charged. If these actions are likely to cause delay for someone who needs an urgent service, the Powys CRHTT should provide the service as the priority based on need and not to wait an agreement about the funding.

If patient is living in Ystradgynlais

In the Ystradgynlais area where there are other health boards operating, the postcode will determine which Crisis Team will be involved. The South Powys CRHTT will be the appropriate CRHTT if the patient pays council tax to Powys.

Triaging and CRHTT Capacity

The number of patients receiving home treatment will be determined after triaging that patient using the Colgate Model and by capacity within the CRHTT. The CRHTT will not refuse a referral due to lack of capacity, but will prioritise work in terms of risk, acuity and complexity.

If the CRHTT are unable to assess a patient because the referral has come in after 19:30, contact will be made, and an appropriate person-centred safety plan will be developed collaboratively with them.

Urgent Access

In the case of immediate acute need or risk, arrangements may be made for the person to be assessed via the Out of Hours process, through A&E, or by utilising Crisis Assessment at Felindre Unit. Arrangements can be made for them to be assessed the next day if safe and appropriate to do so.

CAMHS Patients

Any patients under the age of 18 needing a crisis service should be referred instead to CAMHS Crisis Team. There may be exceptions if a patient is nearly 18 and has been accepted by the CMHT. This could be when a young person is in transition to adult services. They would be referred on a case-by-case basis following discussion with Senior Management Team, with agreement from the CRHTT, and a Datix (incident report) would be completed to record the need and use of the CRHTT service for someone under 18. Out of operational hours the referral will need to go to the EDT or the 111 Press 2 Services.

Older Adult Patients

There is no upper age limit for CRHTT intervention, although patients with a suspected dementia diagnosis should be referred to the Dementia Home Treatment Teams. Links with PCC's Older People's Team are required to ensure that any patients' needs are managed in the least restrictive way possible. PCC has a statutory responsibility to promote wellbeing (both patient and carer) and to prevent an escalation in need.

Patients Without Permanent Powys Address

The absence of a permanent address within Powys is not necessarily an obstacle to engagement with the CRHTT. Assessment and Home Treatment can be offered to any patient resident in Powys who would usually reside in another CRHTT catchment area, subject to individual discussion and close collaboration with other CRHTTs in the best interests of the patient. If the patient requires admission or any other secondary service, this will be provided by their own CRHTT.

CTO recall

This is the responsibility of the RC, and the CRHTT will seek the availability of a bed if requested but are not responsible for arranging a recall. AMHPs have 72 hours to consider revocation if deemed necessary, so it is essential that the AMHP service is involved in the decision to recall.

4.1 – Staff Group

The CRHTT is made up of mental health practitioners who are either nurses, social workers or occupational therapists. We may also have HCSWs.

All CRHTT Staff will have background experience in acute mental health work and will be required to maintain their professional registration through appropriate training and supervision and/or experience, as dictated by their professional bodies.

Minimum staffing will be at least 2 and usually 3 workers.

4.2 – Hours of Operation

The CRHTT will provide a service between the hours of 9am and 9pm, 365 days a year.

5 – REFERRALS

5.1 – Referral Criteria

The individual should be:

- Aged over 18 years.
- Presenting in the Powys catchment area.
- Be in an acute phase of mental health crisis and at risk of hospitalisation to a Mental Health Unit.

5.2 – Referral Process

- Verbal referrals will be taken by the CRHT team, and a triage form completed using the Colgate Model and recorded in the clinical records. If the patient is known to secondary services, it is expected that the care and treatment plan will include an up-to-date WARRN (risk management plan) which will be forwarded to the team as soon as possible.

- If a referral is made following an assessment by an external service, then information must be provided to fully inform the CRHTT of the risks and need for crisis intervention.

- When referring for intensive intervention the clinician referring from the CMHT will have seen the individual the same day. Attempts should be made to contact a current patients care co-ordinator if a referral is made to the CRHTT by another source.

- The patient will remain the responsibility of the referrer until the assessment is completed and the referrer will be informed of this.

- If referrals are not considered appropriate for the CRHTT, a rationale and reasons for the decision will be communicated. This will be recorded in the clinical records with a clear formulation of that decision, aligned to the Colgate Model and clearly detailing any changes to identified risks. Recommendations will be made for signposting to statutory or non-statutory agencies where appropriate. This information will be given to the referrer.

- If the referrer and CRHTT cannot agree on the appropriateness of a referral, it will be considered best practice for the team to offer assessment and to follow up any concerns with the care co-ordinator and team leader and with the referrer. As expected, the CRHTT will require that the patient has been seen in person and assessed by the referrer who will be in the best position to determine that a referral is required.

- From Monday-Friday after 16.00 hrs. all urgent 'crisis' referrals from GPs can be forwarded to the CRHTT but only if the referral is deemed to need to be responded to within 4 hours as detailed in the Colgate Model and cannot wait for the CMHT next day. Discussion with the GP can clarify risk and urgency.

- Having accepted a referral, if the CRHTT are then unable to contact a patient they will inform the referrer of this and seek alternative ways of making contact and further guidance as to risk. The CRHTT will use any other information available to assess this risk.

- The person's GP should be informed the same day as the decision is made.

- If there are indications of high risk, the CRHTT will act appropriately, for example, by ringing relatives or asking for a Police Safe and Welfare check or request the referrer to carry out these checks as appropriate.

5.3 – Referral Source

- Referrals of individuals presenting in the catchment area will be triaged using the Colgate Model and considered for intensive home treatment, hospital admission or early discharge from the following sources:

    - CMHT
    - GP - to be seen by CMHT duty if referral is in CMHT office hours
    - ShropDoc
    - Emergency Duty Teams

- 111 Press 2 Services
- 'On call' Consultant Psychiatrist
- 'On call' Approved Mental Health Practitioners
- Forensic Medical Examiner or Custody Nurse.
- Psychiatric Liaison Services – if admission/admission avoidance is indicated
- Patients can refer themselves under the Mental Health Measure Part 3 if in crisis outside of CMHT office hours
- In exceptional circumstances, referrals will be accepted from Police and Ambulance/health professionals e.g. approved nurse practitioners

NB: Referrals from the police and ambulance services / other health professionals will be considered in the following circumstances:

- The patient is known to local services and has a diagnosed mental disorder and is in mental health crisis. If not known, the individual is presenting in a manner making it highly likely they are in mental health crisis.

- The patient has been assessed in custody by the custody nurse and admission/ admission avoidance is indicated.

- The patient has been seen that day by a medical professional who has not identified a physical cause (including physical health /substance misuse for a deterioration in mental state).

- If substances or alcohol are involved, the patient should be able to Stand, Walk, Talk and be able to engage in a full assessment of their mental state.

- If ambulance/police staff are present, that they remain with the CRHTT worker until a resolution of the presenting problem has been achieved.

- No patient should be brought to a CMHT/CRHTT building or a hospital site unless the local CMHT/CRHTT/hospital have agreed to this in advance.

- If the patient is taken by police to see someone from a mental health service, the patient should be consulted and in agreement to this. They would need to have been assessed to have the capacity to make such an agreement and this should be recorded clearly in the clinical records. CRHTT should also be consulted by the police so that risk history can be evaluated, and safety maintained at all times of all involved in the assessment process.

- The police may request an assessment of the mental health of someone arrested and in a police station, and out of hours this request may come to the CRHTT. They may also request a MHA assessment in a police station. The CRHTT/CMHT **will not** assess fitness to interview or fitness to plead.

- Disposal through appropriate criminal justice routes should also be given due consideration.

In accordance with the Lone Working Policy (HSP 006), CRHTT staff can decline an assessment in an environment where there is sufficient evidence to suggest their safety is compromised or they are unable to take steps to secure their own safety or that of others. A police presence may need to be secured in exceptional circumstances to ensure the safety of staff or other third parties present.

5.4 – Assessments

The CRHTT will participate in all assessments, when admission to in-patient care is a possible outcome and for all patients requiring a Mental Health Act assessment. Exceptions to this will occur and discussion with relevant agencies should be recorded in the clinical records by the CRHTT clinician dealing with the case. Exceptions are likely to be when it is clear via a verbal dialogue that detention is required to support the patient and support at home is not a viable option.

Urgent Assessments

The CRHTT will provide a response to a request for an urgent assessment. Please refer to the Colgate Model for response times and actions which are used in conjunction with all referrals received into the MH services.

Once an assessment is commenced, the CRHTT will remain involved and responsible for the immediate care needs of the patient until a clinical decision is reached and agreed.

Safe Handover of Care

If CRHTT services are not required, but a referral to another service is, the CRHTT will make the appropriate referrals and ensure that the referrer and the patient and or carer is aware of any outstanding/unmet needs. These decisions will be recorded in the clinical records. Please refer to the Safe Handover of Care Principles **(Appendix 3).**

Risk Assessment Tools

Where referrals are considered appropriate for assessment, individuals will be assessed utilising the All-Wales Care & Treatment Plan and WARRN risk management assessment as set out in the Mental Health Measure. This assessment outcome will be summarised to the patient within 10 days and the GP will be provided with a copy.

Dual Diagnosis

The CRHTT will assess people with dual diagnosis. If physical health issue is the primary need, that will take precedence. However, we can assess if someone is experiencing a drug-induced psychosis or a psychosis due to alcohol withdrawal, once deemed medically fit.

Mental Capacity

Where a person lacks mental capacity to give valid consent to CRHTT involvement, although they are not objecting to it, any input will be underpinned by a Mental Capacity assessment and relevant best interest decisions, guided by the Mental Capacity Act (2005). This will be evidenced in the referral process as a 'Best Interest Decision' with the supporting evidence and recorded in the clinical record. The all-Wales MHM assessment and WARRN will be completed. The plan will be formulated following assessment recording the identified need and actions.

Consent to Share Information

'Consent to Share' information will be discussed with the individual and recorded at the earliest opportunity during the assessment pathway. If the patient is reluctant to share the risks they pose to self or others, this will be shared despite objections so that the patient and their family and/or carer has the most relevant and important information to support that patient through the crisis. This will be fully explained at the point of assessment or change of need or risk to the patient, so they understand the duty of care to them but also to the wider support network. If the risk to the patient is determined to come from the carer and/or family, then a safeguarding discussion will be had and any outcomes actioned, which will include a safety plan completed collaboratively with the safeguarding team and or Police where necessary.

Assessment Team

The assessment of a patient, not previously known to secondary services, will be carried out by two registered clinicians for the CRHTT, at least one of whom will be a Band 6 Mental Health Practitioner.

Assessment Bases

Wherever possible the CRHTT assessment will take place in the patient's home and involve key members of their formal and informal support network. Out of hours assessments may need to be conducted in in-patient facilities, primary care centers or other health care premises. The CRHTT will determine the safest place to undertake the assessment which may include the home,

CMHT, MIU, Felindre Ward or a police station if the patient is already in a police station and the police have requested this.

5.5 – Interventions by CRHTT

Interventions may include:

- Ongoing assessment using CTP Framework/monitoring individual's mental state.

- 72-hour assessment will be completed face-to-face with contact each day to enable the CRHTT to determine whether this is sufficient to resolve the issues or whether further intervention is needed. All referrals and assessments completed by the CRHTT considers the immediate needs using the Colgate Model and also the longer-term needs for MH support following the 72-hour assessment under Part 1 and Part 2 of the MH Measures.

- A Care Plan will be given to the patient outlining the CRHTT's planned input, to include any risk management plan in place, which will be shared with family and or carers as indicated above.

- Medication management. Monitoring the effects and side effects of medication (using standard scales and physical observations), information, education and support with the aim of improved concordance.

- Regular liaison with care coordinator, linking into AMHP colleagues should the circumstances deteriorate and there is a need to refer for a Mental Health Act assessment.

- Encouragement and signposting to social, occupational and employment opportunities.

- Short term psycho-social interventions; psychoeducation, anxiety management, problem-solving, brief interventions and crisis planning based upon a recovery approach.

- Information and advice to patients, carers and families, including access to carer's groups, other professionals, and organizations. The family and other support networks are key to a patient's recovery. The CRHTT should complete a consent to share information with family and carers and record this in the clinical records. If risks are on-going with the patient, then this will be shared with carers and family to ensure that all parties are aware of the risks and how these are being managed and supported by the CRHTT.

- Outpatient appointment with a psychiatrist.
- Information about and referral to advocacy service where relevant.
- Regular review of progress with CRHTT team through formal handovers and Clinical Review/MDT meetings.
- As part of the process of assessment and support, the CRHTT may identify the need for further assessment and management of risk. As a team providing short-term support, the CRHTT can refer to the REP even though the patient may be discharged by the time the panel is held. It will sometimes be helpful to attend meetings for patients not currently open to a CRHTT so as to enable the team to consider wider views from REP about risks and the management of risks.

5.6 – Resolution

Planning for discharge from the CRHTT will begin early and in partnership with the existing secondary and/or primary care support. The CRHTT will advise the patient and their carers that the purpose of CRHTT is to enable the patient to return to their usual level of functioning as soon as possible.

Prior to discharge from the CRHTT, the team should ensure:

- That there is good quality of shared understanding of why the crisis occurred and what is required to avoid a re-occurrence.
- That coping strategies have been explored with the patient and their family/carer.
- That a Safety Plan is written with the patient and / or carer and family to help avoid relapse and give information, if further support is needed in the future, and how to access this.
- That a summary of input from the CRHTT will be provided to the referrer, including successful strategies to assist the care coordinator in developing a Crisis/Contingency Plan. For patients discharged to the GP, the CRHTT will devise the Plan. In all cases, a discharge summary will be sent to the GP within 48 hours and recorded on the clinical records on WCCIS.
- That if ongoing care is provided by the Care Co-ordinator, then a discharge planning meeting attended by the CRHTT and Care Co-ordinator to confirm the details of that on-going need should take place prior to discontinuation of the CRHTT. If this is not possible, a discussion/handover is required to

take place between Care Co-ordinator and CRHTT prior to any step down from the CRHTT so to ensure a safe handover of care.

- That a follow-up will then be provided within 5 working days of discharge from the CRHTT as stated in the CMHT Operational Policy.

- The patient, including his/her family or carer, will have had an opportunity to comment on the service they received and contribute to service improvement and development.

- That an assessment and WARRN will be completed and updated during CRHTT interventions and the WARRN will be reviewed and updated before discharge or step down from the CRHTT.

- That if a patient disengages from the CRHTT, this will be discussed in Clinical Review/MDT and agreed as an MDT on the appropriate action based on assessment of risk and need.

- That if a patient has a Care Co-ordinator, the outcome will be discussed with them prior to discharge. If the disengagement seems to be part of a deteriorating presentation, then a discussion or professionals meeting will be held with any other services involved.

- That the CRHTT will take a person-centered approach regarding any patient disengagement. However, the CRHTT are not an assertive outreach team and do need the agreement of the patient to engage with them if they have the capacity to disengage.

- That if we find we cannot see someone or contact them by phone due to non-engagement, and if we have assessed the risk to not to be high, the CRHTT will write to them to advise them of their discharge from the CRHTT and how they can seek further help from Mental Health Services in the future. This will also be communicated with the GP and other services involved. See MHP 075 - Care and Treatment Planning, Part 2, Mental Health Measure (Wales) 2010.

5.7 – Interface with CMHTs

If a known CMHT patient contacts the CRHTT for support, this information will be shared with the CMHT on the next working day. All details regarding the contact will be captured within the electronic patient record.

It is expected that the Care Co-ordinator will remain actively involved in care delivery whilst the patient is under the care of the CRHTT. As a minimum, this would include weekly liaison with the team and review before the

patient's discharge or handover from the CRHTT.

If no Care Co-ordinator exists, the CRHTT named worker will assume Care Co-ordinator responsibilities whilst actively seeking the appointment of a Care Co-ordinator from the CMHT. This will be recorded in the involvement section on WCCIS and recorded in the clinical records. The CRHTT will regularly communicate progress to inform CMHT discussions regarding future needs.

Interface with Mental Health Liaison

Powys CRHTT interface with several MH Liaison Services on a regular basis:

- Bronglais Hospital
- Royal Shrewsbury Hospital
- Hereford Hospital
- Prince Charles Hospital
- The Grange Hospital
- Morriston Hospital
- Princess Royal, Telford
- Neville Hall Hospital

Flow-charts regarding this interface are attached. – See **Appendix 2**.

Engagement from other Hospital Liaison Services will be accepted according to patient need.

Upon receipt of a referral from Hospital Liaison, the clinical information regarding the patient will be transferred onto appropriate MHM paperwork to support process of assessment.

5.8 – Clinical Review

Clinical review meeting/MDT meeting will be held in the CRHTT. Care planning will require a whole team discussion and agreement. The weekly review will provide focused discussion and recording of the following:

- The objectives to be met, in all areas as necessary to achieve the resolution of the current crisis, including practical intervention.

- The frequency of visits. This needs to be flexible enough to respond rapidly to changes in the clinical presentation of the patient.

- Plans for medication administration, whether the patient is obtaining them from the GP thereby self-administering, whether the CRHTT are prompting the individual to take their medication, or whether the CRHTT are administering the medication.

- Any change in risk and positive risk-taking strategies, to include what the CRHTT and others are doing to ensure the risks are managed.
- The Care Plan agreed with the patient, taking account of the views, input, and concerns of family/carers.
- The expected outcome of the CRHTT involvement should be indicated and what needs to change to progress toward discharge to the patient's usual support network.
- Requirement for signposting/referrals to be made.

5.9 – Links with In-Patient Services

- The CRHTT will work collaboratively with in-patient staff at all stages of inpatient care as one of their core functions.
- The CRHTT have a key role in planning for early discharge from hospital.
- Planning for discharge should be started from the time of admission.
- Planning and implementing what is required for an in-patient to be discharged to less restrictive care is a priority and a responsibility shared by in-patient staff, the in-patient liaison officer, care coordinators, responsible clinicians and CRHTT staff.
- The CRHTT will identify all relevant reasons for admission and what needs to change during in-patient stay for home treatment to become a viable option.
- Progress towards discharge will be monitored through joint care review/MDT meetings between in-patient and CRHTT staff. These meetings will focus on the reasons for admission and will identify a planned discharge date.
- The CRHTT will support patients at home, if appropriate, who are on leave from hospital for at least one night.
- If a patient is admitted to the crisis bed out of hours, they will be reviewed the next day and the relevant CRHTT will be involved in this review. This should be in person unless acuity in the service prevents staff from the CRHTT doing this. Such a circumstance will be exceptional. If a patient can return home following use of the crisis bed, the responsibility for transport will remain with the ward, though the CRHTT may be able to do this if appropriate.

- A person who has a S136 assessment on the ward may be referred to the CRHTT as one of the outcomes of this assessment.

5.10 – Links with Learning Disabilities Services

Learning disability should not act as a barrier to acceptance by the CRHTT if the CRHTT is best placed to meet their individual needs. In cases where this is not immediately clear, assessments should be carried out jointly by representatives of both CRHTT and Learning Disabilities Services in hours. Outside of normal operating hours, the CRHTT can access the EDT on-call rota for advice regarding the on-going management of any patient they assess who may fall into the remit of the Learning Disabilities Service.

- If someone with a learning disability is referred who appears not to have capacity in relation to agreeing to be supported by the CRHTT, a formal capacity assessment should be undertaken and recorded in the clinical records. If someone lacks capacity to agree but indicates verbally or through their behaviours that they are likely to accept a service, the CRHTT service should not be ruled out, though joint working with the Learning Disabilities Service will be essential to ensure that the CRHTT are able to understand the needs and wishes of the patient.

- If the CRHTT are supporting a person who does not have a diagnosed learning disability but who the CRHTT identify as possibly having some degree of learning disability, a referral should be made for assessment from the Learning Disabilities Service.

5.11 – Medical Support

The CRHTTs have dedicated medical input. The designated consultants take on RC responsibility for patients while they are on the CRHTT caseload, unless, following consultation, it is judged better for continuity that a current RC continues in the role. Everyone taken onto the CRHTT caseload will be reviewed by a medic at least once. If difference of professional opinion occurs, this should be resolved via a multi-disciplinary discussion and escalated as required.

Out of hours medical support for the CRHTT will be provided by the on-call rotas.

5.12 – Medication / Pharmaceutical Support

CRHTTs are often managing people in the community with complex problems who may require intensive pharmaceutical treatment with challenging and

complex medication needs. Delayed access to supportive medications can exacerbate and could result in hospital admission.

There is in the South a mechanism in place in order to enable CRHTT teams to access medication to support patients within their home environment in order to enable the above. Please see Medications Procedure for CRHTT for further guidance. (currently under review)

5.13 – Lone Worker Risk Management

Members of the CRHTT will work in line with principles set out in the Health Board's Lone Workers Policy (HSP 006).

- Each team member will always record their whereabouts as they enter and leave the team base on the in/out notice board.
- Each team member will report in as safe with the shift coordinator at the end of their allocated shift and at the end of each visit.
- Personal details of each team member will be held in a file in the CRHTT office for use in case of emergency.
- CRHTT workers should always carry a mobile phone whilst on shift.
- Should the worker not call in when expected, the other team members will try to ring them on work and personal mobiles. If there is no response, the CRHTT will ring the patient last visited by the staff member. If this does not resolve the issue, the CRHTT will ring the staff members' next of kin, as recorded. Should this not result in finding the member of staff, the police will be called. The timing of these actions will depend on an assessment of any possible risks to the staff member.

In accordance with the Lone Workers Policy (HSP 006), CRHTT staff reserve the right to decline an assessment in an environment where there is sufficient evidence to suggest their safety is compromised or they are unable to take steps to secure their own safety or that of others. A police presence may need to be secured in exceptional circumstances to ensure the safety of staff or other third parties present.

6 – MONITORING COMPLIANCE, AUDIT AND REVIEW

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

7 – REFERENCES / BIBLIOGRAPHY

National Service Framework for Mental Health (1999)

NHS Plan (2000)

Getting Medicines Right 2 (2010)

Mental Health Crisis Care Concordat (2014)

NICE: Service User Experience in Adult Mental Health; Improving the Experience of Care for People Using Adult NHS Mental Health Services (2011)

Mental Health Act 1983 revised (2007)

Social Services and Wellbeing Act (2014)

Mental Capacity Act (2005)

APPENDIX 1

Felindre Crisis Beds Policy

1. Introduction

Felindre ward introduced 2 crisis beds on the unit ready for the transfer to Powys Teaching Health Board. The crisis beds are only to be used out of hours for crisis/emergency admissions between the hours of 5pm and 9am and during weekends and bank holidays.

The purpose of the crisis beds is to ensure that there is always a bed available should a person require an out of hours assessment and requires a hospital admission. The Crisis beds are not to be occupied by the same patient for more than 24 hours.

Felindre crisis beds are not to be included in overall bed numbers. Felindre is a 12-bed unit and should not be considered as a 14-bed unit.

2. Objective

For PTHB to be able to provide an out of hours service for the patients that require a crisis admission out of hours.
Crisis beds are to be used for patients who have not been reviewed by a psychiatrist – due to being out of hours.
The patient admitted to the crisis beds will be reviewed by psychiatrists the following day and a plan devised following this review.

3. Definitions

PTHB – Powys Teaching Health Board
WARRN- Welsh Applied Risk Research Network
HTT – Home Treatment Team
WTE- Whole Time Equivalent

4. Responsibilities

Ward manager / Nurse Assessors/ Home treatment team clinicians to ensure that procedure is followed correctly during a crisis admission during an out of hours period.

4.1. Staff Group or Specific Role

- Nurse Assessors – Felindre ward has 6 WTE band 6 nurse assessors on the unit. The role of the nurse assessor is to complete out of hours assessments, risk assess and complete a management plan for the patient assessed. The Nurse will complete the admission Proforma, WARRN risk assessment.
- Home treatment team workers – Should a member of the HTT feel a

person requires an admission out of hours then they will have use of a crisis bed. The person will be admitted to the Crisis bed and reviewed by team medics the following the day.

5. Procedure for use of crisis beds:

5.1 South Powys:

Following an assessment: Should an assessment be conducted after 5pm either by HTT or the Nurse assessor on Felindre ward, and it is deemed the person requires an admission to the unit, then the person will be admitted into the crisis bed overnight. The person will be reviewed the following morning by the CRHTT, and the outcome discussed with medic, a plan will be devised for the person.

If after review, it is identified that the person requires a longer period of inpatient stay, then the person will be transferred to a bed on Felindre Unit.

If after review it is deemed that the person no longer requires an inpatient stay, the person will be discharged from the ward. CMHT's and GP will be notified of assessment/admission/discharge details.

If a patient has been assessed by a medic and it is that the person requires a period of stay on Felindre – the crisis beds are not to be used in this instance, the patient should be allocated a bed on the ward.

5.2. North Powys:

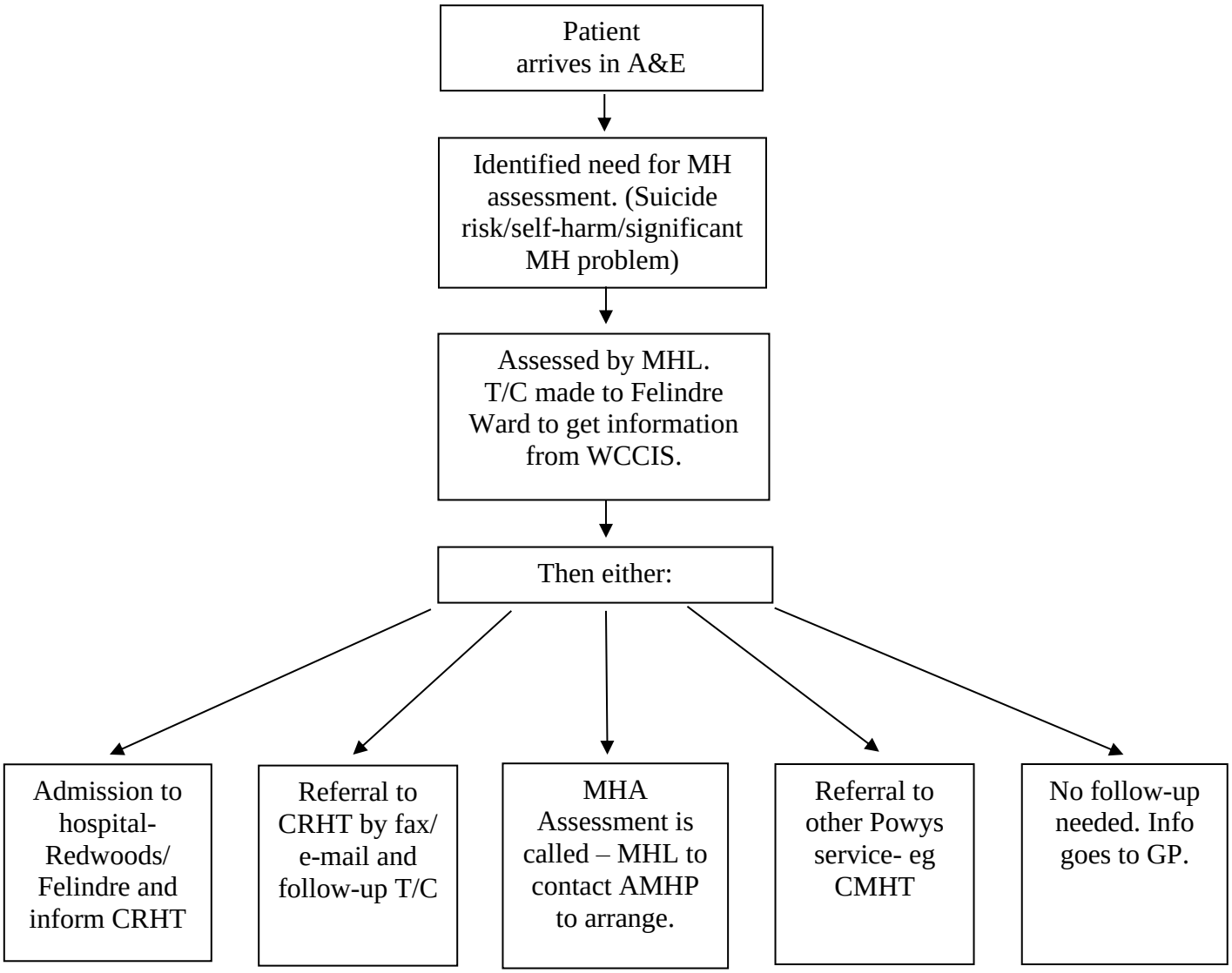
Patients assessed out of hours in North Powys require a review by the on-call medic.

Due to the patient being assessed by Medic the patient will not require the use of the crisis bed. Therefore, a bed should be sought firstly In Redwoods and secondly Felindre ward.

A patient being admitted from North Powys will need to attend the ward with a completed Medication chart, admission proforma completed – indicating any risks/medical & Physical illness/issues, reasons for admission and management plan. Should the medic not have access to admission paperwork, then detailed clinical notes should be present. This will need to include reasons for admission, past and current mental state, physical health/allergies, risks- past and current, level of observations and plan.

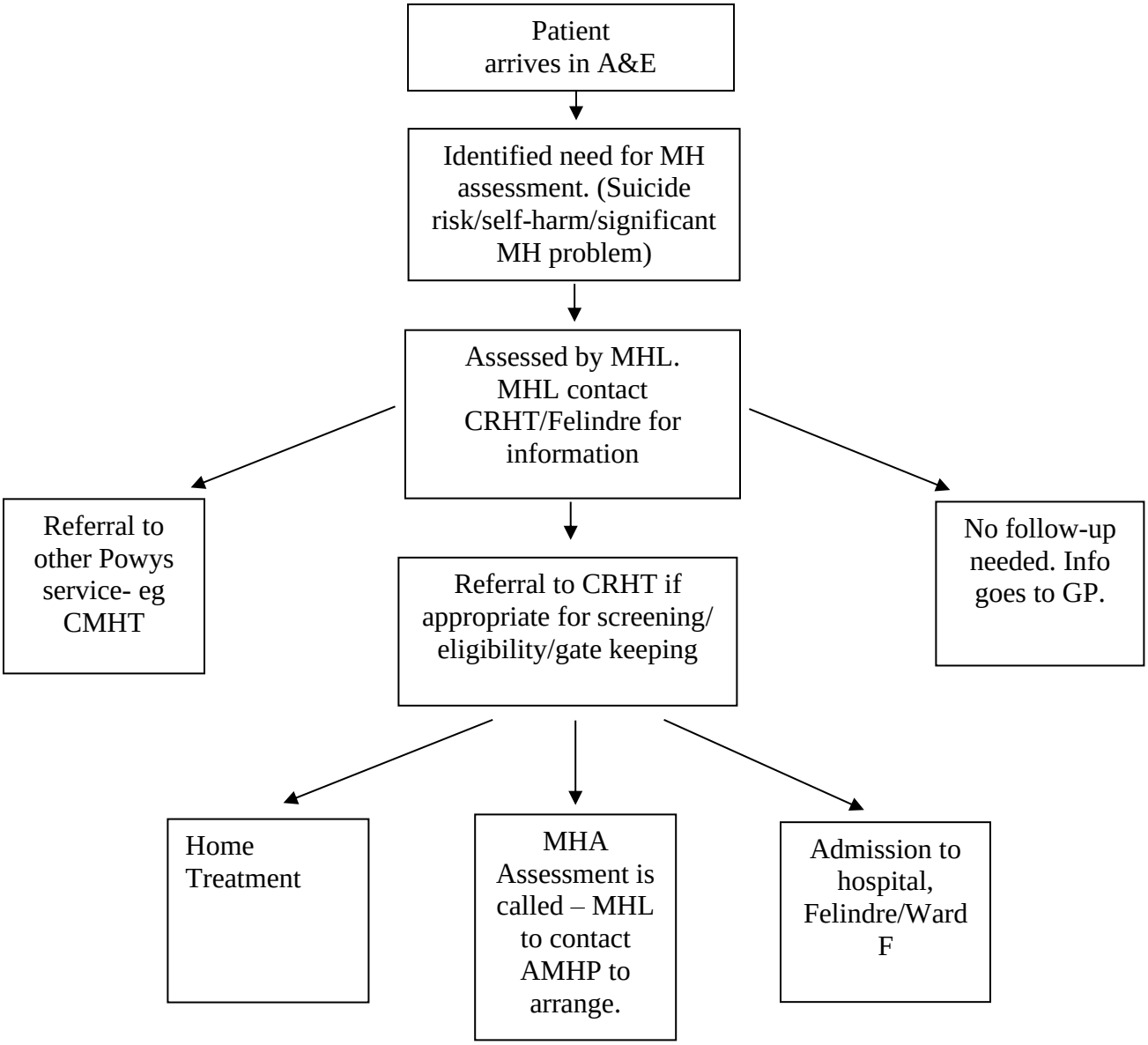
APPENDIX 2

Referrals from MHL RSH to North Powys CRHTT



Insert Colgate Model

Referrals from MHL to South Powys CRHTT



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APPENDIX 3 – SAFE HANDOVER OF CARE KEY PRINCIPLES