Jersey Care Commission
Care Standards
Service Specific Requirements
Crisis Resolution and Home Treatment Team

Several of the service specific standards for Crisis Resolution and Home Treatment Team are covered by the Community Mental Health standards. Due to the size of local services and the close working between teams the inspectors will not be required to repeat the data collection.

Standards highlighted in purple are specific to Crisis Resolution and Home Treatment Team. Those that are prefaced with "Covered in Community MH 00.0.0" refer to where that standard is reviewed.

Safe
Effective
Caring
Responsive
Well-led

SAFE

Standard 2. Learning Culture

We have a positive and proactive culture of safety based on openness and honesty. We listen to safety concerns, investigate and report safety events thoroughly, and learn from them to improve and embed good practices.

What this means to people:
I can voice safety concerns and the service takes these concerns seriously, investigates thoroughly, and learns from any safety incidents to improve practices.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 17 Workers
Regulation 22 Complaints and representations
Regulation 71 Requirements in respect of complaints procedure

2.2 Service Specific Requirements

2.2.1 **Covered in Community MH 21.2.3** (All patient information is kept in accordance with current legislation. This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access).

2.2.2 **Covered in Community MH 5.2.2** (The service is developed in partnership with appropriately experienced patients and carers and have an active role in decision making).

2.2.3 The team is actively involved in quality improvement activity.

2.2.4 **Covered in Community MH 2.2.5** (The team actively encourages patients and carers to be involved in QI initiatives).

2.2.5 **Covered in Community MH 5.2.1** (The team asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service).

2.2.6 **Covered in Community MH 3.2.1** (The team reviews data at least annually about the people who use it. Data are compared with local population statistics and action is taken to address any inequalities of access that are identified).

2.2.7 **Covered in Community MH 14.2.2** (The service's clinical outcome data are reviewed at least six-monthly. The data are shared with the senior management team, the team, patients, carers and wider the organisation, and used to make improvements to the service).

SAFE

Standard 3. Safe systems, pathways and transitions

We work with people and our partners to establish and maintain secure care systems. We manage, monitor, and ensure safety. We make sure that care is continuous, even when people move between different services.

What this means to people:
I know what to do and who I can contact when I realise that things might be at risk of going wrong, or my health condition may be worsening. When I move between services, settings or areas, there is a plan for what happens next, who will do what, and all the practical arrangements are in place.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared responsibilities

3.2 Service Specific Requirements for CRHTT

3.2.1 The team's acceptance criteria include people that have self-harmed, have substance use needs, dual diagnosis, learning disability or personality disorder.

3.2.2 The team is able to respond to requests for gatekeeping assessments. This should include Accident & Emergency departments, mental health liaison teams, GP's, mental health services and agencies other than health services which support people with mental health problems.

3.2.3 **Covered in Community MH 6.2.1** (The team's base environment is clean, comfortable and welcoming).

3.2.4 **Covered in Community MH 6.2.2** (Clinical rooms are private, and conversations cannot be overheard).

3.2.5 **Covered in Community MH 6.2.3** (The environment complies with current legislation on accessible environments. Relevant assistive technology equipment, such handrails, are provided to meet individual needs and to maximise independence).

3.2.6 **Covered in Community MH 6.2.5** (There is a system by which staff are able to raise an alarm if needed. Guidance: This includes at the team's base and for lone working).

3.2.7 The home treatment team, or another specialist mental health service, is able to undertake assessments 24 hours a day, 7 days a week. If an assessment is delegated to another service out of hours, the home treatment team is fully aware of those assessments and monitors their quality.

3.2.8 The team has the capacity to allow for two home visits over a 24-hour period for each patient as clinically required. Guidance: A number of patients may require a minimum of two visits to monitor and administer medications and/or as part of identified clinical needs.

3.2.9 The team provides information about how to make a referral and waiting times for assessment and treatment.

3.2.10 The team is able to conduct assessments in a variety of settings.

3.2.11 The patient reaches an agreement with the team about where they would like their assessment to take place and the team is able to conduct visits remotely. Guidance: Visits could be conducted via, for example, Skype or FaceTime.

3.2.12 The team assess patients, who are referred to the service, within an agreed timeframe and the outcome is agreed with the referrer. Guidance: This should not be in more than 24 hours.

3.2.13 **Covered in Community MH 24.2.7 (**The team works with interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances).

3.2.14 The team provides information in advance of the assessment to patients that includes:

- The name and title of the professional they will see.
- An explanation of the assessment process
- Information on who can accompany them.
- How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).

3.2.15 The patient's primary carer(s) or nearest relative(s)/person are identified and recorded in the assessment.

3.2.16 The patient is asked who they would like to be present during the assessment and their family/carers and relevant others, e.g. independent mental health advocate, are invited to be involved in the assessment. Possible relationship tensions are considered when organising the assessment.

3.2.17 The team ensure that the patient and their family/carers understand the purpose of the assessment.

3.2.18 Patients receive a comprehensive evidence-based assessment which includes their:

- Mental health and medication
- Psychosocial and psychological needs
- Strengths and areas for development.

3.2.19 A physical health review takes place as part of the initial assessment, or as soon as possible. The review includes but is not limited to:

- Details of past medical history;
- Current physical health medication, including side effects and compliance with medication regime;
- Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.

3.2.20 **Covered in Community MH 11.2.10** (Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan).

3.2.21 The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.

3.2.22 The routine assessment includes identification of dependants and their needs, including childcare issues, and any young or adolescent carers, and other people affected by the crisis and associated risk to them. This includes the names and dates of birth of any young people. If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment.

3.2.23 The routine assessment includes planning for supported transition to other services.

3.2.24 Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation.

3.2.25 **Covered in Community MH 10.2.7 (**All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised).

3.2.26 Patients have a risk assessment and management plan which is co-produced where possible, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.

3.2.27 The team follows up patients who have not attended an appointment/ assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. Where patients consent, the carer is contacted.

3.2.28 If a patient does not attend for an assessment, the assessor contacts the referrer. If the patient is likely to be considered a risk to themself or others, the team contacts the referrer immediately to discuss a risk action plan.

3.2.29 While identifying patients for home treatment to facilitate early discharge, consideration is given to the increased risk of suicide post-discharge from hospital.

3.2.30 The team works within the Community Mental Health Framework for Adults and Older Adults, promoting assessment and interventions, coordinating and planning care, community connection.

3.2.31 **Covered in Community MH 3.2.9 (**Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan, and they are offered a copy. Where possible, the patient writes the care plan themselves or with the support of staff).

3.2.32 Patients' existing crisis plans are identified, utilised by the team and shared with family/carers where appropriate, in the event that they require home treatment.

3.2.33 **Covered in Community MH 5.2.3 (**Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management).

3.2.34 **Covered in Community MH 14.2.2** (Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge).

3.2.35 The team has a nominated medicines management lead.

3.2.36 Patients prescribed medication have a medicines chart, and all medicines that are administered or supervised by the team are recorded on the chart.

3.2.37 The team has rapid access to medication, 24 hours a day.

3.2.38 The team has 24 hour access to prescribing advice from a consultant psychiatrist or independent non-medical prescriber.

3.2.39 On admission to the home treatment team, a team member will obtain a medication history from the patient, as well as contact the patient's GP and carer or get access to Summary Care Record to obtain a copy of their medicines records as per Health and Community Services Medicines Reconciliation policy. This includes current medicines for mental and physical health, medicines history, recent laboratory results and any other issues which may impact on medicines.

3.2.40 **Covered in Community MH 9.2.1 (**When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded).

3.2.41 **Covered in Community MH 11.2.13** (Patients who are prescribed mood stabilisers or antipsychotics are offered and encouraged to have the appropriate physical health assessments at the start of treatment and continued as per NICE guidance. This will need to be communicated to the community mental health team or the GP to continue the physical monitoring on discharge).

3.2.42 **Covered in Community MH 9.2.2 (**Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Side effect monitoring tools can be used to support reviews).

3.2.43 The plan for managing medication concordance is agreed with family/carers, and reviewed regularly.

3.2.44 Patients (and their carers, with patient consent) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.

3.2.45 Patients and carers are able to discuss medications with a specialist pharmacist.

3.2.46 Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.

3.2.47 The team is able to provide a range of therapies to patients and their family/carers based on need. Interventions could be drawn from the following approaches:

- Cognitive Behavioural Therapy (CBT) approaches including Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT)
- Psychodynamic approaches including Interpersonal Psychotherapy (IPT) and Cognitive Analytic Therapy (CAT)
- Psycho-educational approaches
- Solution-Focused Brief Therapy (SFBT)
- Problem-Solving approaches
- Family Interventions for Psychosis
- Motivational Interviewing
- Person-Centred approaches
- Systemic approaches
- Stress management

- Supportive counselling
- Relapse prevention.

3.2.48 **Covered in Community MH 11.2.9** (Staff members who deliver therapies and activities are appropriately trained and supervised).

3.2.49 **Covered in Community MH 11.2.8** (The team supports patients to undertake structured activities such as work, education and volunteering. For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This includes referral to the Individual Placement and Support service where appropriate).

3.2.50 The team supports patients to access local green space on a regular basis. This could include signposting to local walking groups or arranging regular group activities to visit green spaces. Consideration should be given to how all patients are able to access these sessions including for example access to appropriate foot or rain wear.

3.2.51 Involvement of the team is time-limited, and people are discharged when acute care is no longer necessary.

3.2.52 The home treatment team begins discharge planning at the point of assessment with the patient and their carer, where appropriate, and this is communicated to relevant parties.

3.2.53 A clear discharge plan is given to the patient on discharge and sent to all other relevant parties within 48 hours of discharge. This plan includes details of:

- On-going care in the community/aftercare arrangements
- Crisis and contingency arrangements including details of who to contact
- Medication, including monitoring arrangements
- When, where and who will follow up with the patient as appropriate.

3.2.54 Clinical outcome measurement is collected at two time points (at assessment and discharge). This includes patient-reported outcome measurements where possible.

3.3 Service Specific Requirements for CRHTT - Older Adults

3.3.1 When patients don't have capacity to consent, best interests processes described within the Capacity and Self-Determination (Jersey) Law 2016 and code of practice will be followed.

3.3.2 Mental health practitioners carry out an assessment of the patient's personal, social, safety and practical needs to reduce the risk of suicide at the point of referral.

3.3.3 Patients are advised/signposted for follow-up investigations and treatment when physical health needs are identified.

3.3.4 Where there is possible cognitive impairment, the team links patients to the memory service.

3.3.5 **Covered in Community MH 3.2.9** (There are systems in place to ensure that the service takes account of any advance care plans (e.g. advance directives, advance statements, Lasting Powers of Attorney, Enduring of Power of Attorney in Northern Ireland) that the patient has made. These are accessible and staff know where to find them).

3.3.6 A designated lead for older people's mental health attends a forum which meets quarterly, and includes the discussion of key operational, clinical and governance issues including safety.

3.4 Service Specific Requirements for CRHTT – Children and Young People

3.4.1 Staff have appropriate training for working with people aged under 18.

Guidance: Training includes:

- Providing advice when conducting triage assessments
- Signposting to other local services
- Legal issues relevant to working with children and young people
- Ability to engage and work with families, parents and carers
- Ability to communicate with children/young people of differing ages, developmental levels and background.

3.4.2 All clinical mental health staff working with young people under 18 have Level 3 training in Child Protection/Safeguarding.

3.4.3 Procedures are in place to identify young people under 18 who are on the Child Protection Register. Staff can liaise with Child Protection and Social Work colleagues for safeguarding advice and management at all times if required.

3.4.4 Staff refer children and young people, with consent, to local organisations.

3.4.5 If a young person raises safeguarding concerns or someone else raises concerns about them, staff are able to act in accordance with child protection protocols.

3.4.6 There is a lead for children and young people. The lead meets regularly with local CYP mental health services.

3.4.7 There is specific transition plan, with CRHTT input where a young person is transferred between CAMH services and adult mental health services.

3.4.8 For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant CYP Services.

3.5 Service Specific Requirements for CRHTT – Crisis Line Response

3.5.1 The team provides support, screening and triage assessments to identify the appropriate care option for people presenting in a self-defined mental health crisis.

3.5.2 The team is available 24/7 and is accessible through dialling 111 or via a local access number.

3.5.3 A trained and experienced mental health staff member will undertake an initial triage assessment to ascertain if the caller is the person in crisis or a carer' of a person in crisis.

3.5.4 All face-to-face urgent and emergency assessments are carried out by qualified mental health staff.

3.5.5 The team has an agreed time for providing a face-to-face response for urgent and emergency referrals. Within four hours for an emergency crisis mental health response and 24 hours for urgent.

3.5.6 Staff have received appropriate training (see appendix as a guide) for responding to people presenting in a crisis over the phone. This could include crisis counselling skills over the phone.

3.5.7 An appropriate telephone outcome is evidenced based such as by use of UK triage scale or any other locally agreed triage framework to determine the urgency of response.

3.5.8 There is a protocol and staff are aware to follow when there is a urgent physical health need or alternation in the person's physical health. This includes any problems regarding intoxication and escalating to blue light services.

3.5.9 A face-to-face assessment is carried out at the most appropriate location, with the safety of staff and the patients being considered paramount.

3.5.10 The crisis line may signpost to appropriate community services in line with the person's individual needs.

3.5.11 The team provides professional advice to other teams and services such as GPs, police, paramedics and social care.

3.5.12 Once a face-to-face assessment is completed the details are sent to the patient's GP, the patient themselves and other identified professionals involved in the patient's care within 72 hours.

3.5.13 The team has an escalation protocol in place for supporting complex or patients that are high-risk.

3.5.14 A senior member of staff/clinical is available to provide advice to the team 24/7.

3.5.15 There are systems in place to meet the clinical needs for high intensity users. This may include joint working with CMHTs, psychiatric liaison teams, emergency department staff and other relevant professionals.

3.5.16 If a patient needs to go to the Emergency Department, staff liaise with the psychiatric liaison team to inform them of their plans to attend and clinical information.

3.5.17 Patients and carers, with patient consent, are offered to be involved in decisions about their care and treatment through the crisis line where appropriate.

3.5.18 The team monitors the time taken to answer calls and the drop call rate.

3.5.19 There is a system for text solutions for patients who have a hearing impairment.

3.5.20 The team have a clear process for contacting family/carers where the patient does not consent to their involvement or does not wish to engage.

3.5.21 The team has a clear pathway with approved mental health professional (AMHP) services for initiating Mental Health Law assessments.

SAFE

Standard 7. Safe and effective staffing

We make sure there are enough qualified, skilled, and experienced staff who are well supported and receive effective supervision and development. They work together effectively to provide safe care that meets people's individual needs.

What this means to people:

- I always receive safe care and treatment delivered by competent staff
- Staffing levels and skills are planned and reviewed to provide safe care
- I know who my named nurse or key worker is and know how to contact them

Relevant subtopics covered by this standard

Safe recruitment
Staffing levels and skills mix
Skills and qualifications/revalidation
Learning, development and competency
Support, supervision
Performance management
Volunteers and unpaid carers

Relevant regulatory requirements

Regulation 2 Fitness criteria
Regulation 8 Person-centred care
Regulation 17 Workers

7.2 Service Specific Requirements

7.2.1 The team has a team lead.

7.2.2 The team has dedicated registered mental health nurse(s).

7.2.3 The team has dedicated social worker(s).

7.2.4 The team has dedicated support worker(s). For example, healthcare assistant, occupational therapist support worker, psychology assistant, etc.

7.2.5 The team has input from pharmacist(s).

7.2.6 The team has dedicated consultant psychiatrist(s).

7.2.7 The team has dedicated non-medical prescriber(s).

7.2.8 The team has access to occupational therapists. To provide an occupational assessment for those patients who require it; to ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.

7.2.9 The staff team has access to peer support worker(s). A patient or carer representative employed by the team to support other patients and/or carers.

7.2.10 The team has access to administrative assistance to meet their needs.

7.2.11 The staff team has access to psychologist(s).

7.2.12 The psychologists are able to provide a range of direct and indirect interventions, enabling access to psychological interventions to 70 – 75% of patients.

7.2.13 There is access to input from arts or creative therapists.

7.2.14 **Covered in Community MH 7.2.1** (The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:

- A method for the team to report concerns about staffing levels
- Access to additional staff members
- An agreed contingency plan, such as the minor and temporary reduction of non-essential services).

7.2.15 **Covered in Community MH 7.2.2** (When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member).

7.2.16 There is an identified senior clinician available at all times who can attend the team base within an hour. Some services may have an agreement with a local GP to provide this medical cover.

7.2.17 Patient or carer representatives are involved in the interview process for recruiting potential staff members. These representatives should have experience of the relevant service.

7.2.18 The team has a timetabled meeting at least once a day to current assessments and reviews.

7.2.19 Staff receive a formal induction programme, by the end of which they understand the functions of the team, including the principles of home treatment services.

7.2.20 **Covered in Community MH 7.2.5** (New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met).

7.2.21 **Covered in Community MH 7.2.10 (**Staff have an annual appraisal and personal development planning).

7.2.22 **Covered in Community MH 7.2.6 (**Clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their professional body. Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications).

7.2.23 **Covered in Community MH 7.2.7 (**Staff members receive individual line management supervision at least monthly).

7.2.24 **Covered in Community MH 28.2.1** (Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice).

7.2.25 Team managers and senior managers promote positive risk-taking to encourage patient recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.

7.2.26 The whole team meet monthly to discuss service development. The meeting is structured to ensure staff can contribute meaningfully to discussions.

7.2.27 The service actively supports staff health and well-being. For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.

7.2.28 **Covered in Community MH 20.2.2** (Staff members are able to take breaks during their shift that comply with the European Working Time Directive. Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks).

7.2.29 **Covered in Community MH 28.2.2** (Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing).

7.2.30 Staff take part in team building on an annual basis, training in colleague support and working within the team framework.

7.2.31 **Covered in Community MH 20.2.3** (Staff members, patients and carers who are affected by a serious incident are offered post-incident support. This includes attention to physical and emotional wellbeing of the people involved and post incident reflection and learning review).

7.2.32 **Covered in Community MH 11.2.12** (The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. This includes guidance about when to call 999).

7.2.33 Staff receive training in the inequalities in mental health access, experiences and outcomes for patients with protected characteristics.

7.2.34 Staff have received training in delivering crisis resolution/home treatment interventions. This may include psychosocial interventions, conflict resolution, activity scheduling, solution focussed brief therapy, family and social systems interventions, values-based practice, and skills to respond appropriately to self-injurious or suicidal behaviour.

7.2.35 Staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.

7.2.36 Staff who administer and/or deliver medication have received training as required by their role and are assessed as competent on an annual basis. This could include storage, administration, legal issues, encouraging concordance and awareness of side effects and secure handling of medications and stationery (e.g. FP10).

7.2.37 Staff have received training on the use of legal frameworks, including the Mental Health (Jersey) Law 2016 and Capacity and Self Determination (Jersey) Law 2016.

7.2.38 Staff have received training on safeguarding vulnerable adults and children. This includes recognising and responding to the signs of abuse, exploitation or neglect.

7.2.39 Staff have received training in risk assessment and risk management. This includes assessing and managing suicide risk and self-harm.

7.2.40 Staff have received training in alcohol and substance use.

7.2.41 Patient and carer representatives are involved in delivering and developing staff training.

7.2.42 Staff have received training in physical health assessment. This could include training in understanding physical health problems, undertaking physical observations, basic life support and when to refer the patient for specialist input.

7.2.43 Staff have received training in recognising and communicating with patients with cognitive impairment and learning disabilities.

EFFECTIVE

Standard 11. Delivering evidence-based care and treatment

We work with people to plan and provide care and treatment, considering what matters to them. Our approach aligns with the law and follows the latest evidence-based best practices and standards.

What this means to people:

- I am involved in the planning of my treatment and care.
- I am able to influence important decisions about my treatment and care.
- I can give or withhold my consent freely.
- The care I receive is personalised to my preferences and supported by best practice.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 9 Personal plans and care records
Regulation 12 Cleanliness and infection control
Regulation 13 Nutrition and hydration
Regulation 14 Management of medicines
Regulation 16 Control and restraint

11.2 Service Specific Requirements

11.2.1 There are measures in place to ensure staff are as safe as possible when conducting home visits. These include:

- Having a lone working policy in place
- Conducting a risk assessment
- Identifying control measures that prevent or reduce any risks identified.

11.2.2 Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.

11.2.3 Confidentiality and its limits are explained to the patient and their carer at the initial assessment, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.

11.2.4 Policies/protocols are reviewed at least every three years. Guidance: This includes assessing for equality impact at least every three years, to ensure equality of service.

11.2.5 The team follows a protocol to manage patients who disengage from the service against the team's advice. This includes:

- Recording the patient's capacity to understand the risks of self-discharge
- Putting a crisis plan in place
- Contacting relevant agencies to notify them of the discharge
- Following locally agreed protocols
- Escalating concerns.

11.2.6 **Covered in Community MH 14.2.2** (Systems are in place to enable staff members to report incidents quickly and effectively, and managers encourage staff members to do this).

11.2.7 When serious mistakes are made in care, this is discussed with the patient themself and their carer, in line with Duty of Candour.

11.2.8 **Covered in Community MH 2.2.3** (Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons).

11.2.9 There is a written policy governing self-administration of medication, including supervision of the patient and recording.

11.2.10 There is a written policy governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self -harm.

EFFECTIVE

Standard 12. How staff, teams and services work together

We collaborate well between teams and services to help people. We ensure that people who use services only have to tell their story once, by sharing their needs assessment when they move between different services.

What this means to people:

- I only have to tell my story once, and the care I receive is based on teams working together, even when I move between services
- I can expect that all information provided will be treated confidentially and held securely
- My care records will be shared appropriately with my knowledge and consent and on a need to know basis.

Relevant regulatory requirements

Regulation 8 Person-centred care
Regulation 15 Shared Responsibilities

12.2 Service Specific Requirements

12.2.1 The team is able to refer to child and family support services including child protection.

12.2.2 Patients with drug and alcohol problems are supported/signposted to access specialist help e.g. drug and alcohol services.

12.2.3 Health records are accessible by other teams who may be involved with the patient's care during the episode. This could include psychiatric liaison teams, Emergency Department, acute inpatient wards and primary care.

12.2.4 The team has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:

- Assessment
- Care and treatment (particularly relating to prescribing psychotropic medication)
- Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.

12.2.5 There is active collaboration between Children and Young People's Mental Health Services and Working Age Adult Services for patients accessing the home treatment team who are approaching the age for transfer between services.

12.2.6 Outcomes of referrals are fed back to the referrer. If a referral is not accepted, the team advises the referrer of alternative options. The rationale and discussion are documented in the patient's notes.

12.2.7 The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The patient receives a copy.

12.2.8 The team works closely with acute inpatient care, including gatekeeping and facilitating early discharge. This can be achieved by operational policies, ward rounds, joint acute care reviews, supported leave arrangements, sharing the same base location, shared consultant responsibility or shared acute care workers.

12.2.9 The team gatekeeps acute inpatient beds. Guidance: This can be achieved by face-to-face contact or jointly agreed through discussion with the other team e.g. the liaison team.

12.2.10 If hospitalisation is required, the patient is informed of the reasons why home treatment was not appropriate, the purpose, aims and outcome of the admission.

12.2.11 The patient and their carers are involved in discharge planning from acute inpatient services to the home treatment team.

12.2.12 The team offers home treatment on transfer from acute inpatient services within 24 hours of discharge, where clinically indicated.

12.2.13 The home treatment team is able to transfer care to a community mental health team as required.

12.2.14 Local information systems are capable of producing accurate and reliable data about delayed transfers from the home treatment team to the community mental health team, and action is taken to address any identified problems.

12.2.15 Teams provide support to patients when their care is being transferred to another community team, or back to the care of their GP.

12.2.16 When patients are transferred between community services there is a handover which ensures that the new team has an up-to-date care plan and risk assessment.

12.2.17 When patients are transferred between community services there is a meeting in which members of the two teams meet with the patient and their family/carer to discuss transfer of care.

12.2.18 The team, inpatient and community teams meet at least weekly to discuss key clinical information. Guidance: This could include regular meetings with inpatient and community services or sharing of information via an agreed pathway.

12.2.19 The team has access to a crisis house.

12.2.20 Clinical responsibility while the patient is in a crisis house is clearly defined. This should include communication protocols, visiting frequency, reviews, etc.

12.2.21 Responsibility for the storage and administration of medication while the patient is in a crisis house is clearly defined.

12.2.22 There are arrangements for emergency medical care while the patient is in a crisis house.

RESPONSIVE

Standard 21. Person-centred care

We make sure people are at the centre of their care and treatment choices, and we decide, in partnership with them, how to respond to any relevant changes in their needs.

What this means to people:
I have care and support that is coordinated, and everyone works well together with me.

Relevant regulatory requirements

Regulation 7 Respect and involvement
Regulation 8 Person-centred care
Regulation 9A Need for consent

21.2 Service Specific Requirements

21.2.1 The team contacts the patient and their family/carers to agree on contact times, frequency and duration of contact, and ensures they are informed about unavoidable delays.

21.2.2 Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:

- Their rights regarding admission and consent to treatment
- Rights under the Mental Health (Jersey) Law 2106
- How to access advocacy services
- How to access a second opinion
- How to access interpreting services
- How to view their health records
- How to raise concerns, complaints and give compliments. This could be online or in paper format.

21.2.3 Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.

21.2.4 Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.

21.2.5 Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.

21.2.6 The team supports patients to access:

- Housing support
- Support with finances, benefits and debt managementF
- Social services.

21.2.7 Staff are knowledgeable about local organisations who can provide support to children and young people and their waiting times. This can include apps and services available digitally.

21.2.8 Before discharge, crisis plans are reviewed and explained to the patient, with the involvement of their care coordinator (where allocated), and support is provided to complete these.

21.2.9 Patients can access help from mental health services 24 hours a day, seven days a week.

21.2.10 Staff members treat patients and carers with compassion, dignity and respect.

21.2.11 Patients feel listened to and understood by staff members.

21.2.12 Patients feel welcomed by staff members when attending their appointments. Staff members introduce themselves to patients, and address patients using the name and pronouns they prefer.

21.2.13 Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. This includes attendance at review meetings where the patient consents. This includes the opportunity to discuss risk management, where appropriate.

21.2.14 Carers are supported to access a carers' assessment, provided by an appropriate agency. This advice is offered at the time of the patient's initial assessment, or at the first opportunity.

21.2.15 Carers are offered individual time with staff members to discuss concerns, family history and their own needs.

21.2.16 The team provides each carer with accessible carer's information. Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.

21.2.17 There is a designated staff member to promote carer involvement.

21.2.18 The service actively encourages carers to attend carer support networks or groups.

21.2.19 If the carer is 25 or under, contact with Young Carer, or Young Adult Carer services is facilitated.

21.2.20 Carers are given information on mental health problems, what they can do to help, their rights as carers and an up-to-date directory of local services they can access.

21.2.21 The team knows how to respond to carers when the patient does not consent to their involvement. The team may receive information from the carer in confidence.