

Standards for Ensuring Effective Acute Care Pathways in Mental Health Services

Document History

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Standards for Ensuring Effective Care Pathways in Community Mental Health Teams and Acute Services North Staffordshire Combined Healthcare

1. Managing the Admission of known Service Users to Acute Inpatient Wards

- 1.1. All requests for admission must be made to the Crisis Resolution & Home Treatment (CR/HT) teams, who will assess for appropriate care management in the community or possible admission.
- 1.2. The Care Co-ordinator will provide relevant information to the CR/HT teams prior to any assessment taking place. **It is essential that the Care Co-ordinator must be part of the assessment.** This means that the Care Co-ordinator is actively involved in the information sharing and decisions making that are part of the assessment in order to ensure adequate continuity and effective assessment as well as minimising the need for the Service User to have to repeat their histories unnecessarily.
- 1.3. When the CRHT assesses a Service User outside normal working hours and the Care Co-ordinator cannot be part of the assessment then the CRHT will inform the Care Co-ordinator of the outcome of the assessment on the next working day.
- 1.4. All Service Users who are admitted to an in-patient ward without the involvement of the CRHT to assess their suitability to receive domiciliary acute care as an alternative to hospital admission must be reported to the Acute Services Manager.
(Department of Health 2000, NIMHE 2004, Healthcare Commission 2007)

2. Operational Standards for Managing the Acute Care Pathway, “Acute In-reach”,

- 2.1. When any Service User receives treatment from any of the acute services, **the care co-ordinator will continue to provide face-to-face contact with the Service User** for a minimum of 30 minutes per week. **If there are exceptions, then they should be recorded in the notes.**
- 2.2. As appropriate the Care Co-ordinator or nominated person will maintain contact with the Service Users’ family / carers.
- 2.3. This contact with the Service User could be ward based or a home visit or any other place as required.
- 2.4. All circumstances where it is deemed appropriate not to have face-to-face contact with the Service User should be considered as exceptional and the reasons for each exception should be reported to the appropriate Team Manager and be documented by the Care Co-ordinator or nominated person in the Service Users’ clinical record.
- 2.5. In addition to the above Service User contact, the care coordinator or a nominated staff member will make weekly contact with the Service User’s Acute “Keyworker” or “Named Nurse” in the acute team for a minimum of 30 minutes per week to exchange relevant information to

co-ordinate the care and pathway. This can be face to face (in which case it can take place when the care co-ordinator is on the ward, not necessarily at a ward round or review) or it can be a telephone contact.

- 2.6. This weekly contact between care co-ordinator and Acute “Keyworker” or “Named Nurse” (acute services) may include, but is not confined to formal care planning/review meetings or ward round meetings.

3. Allocating a Care Co-ordinator to Service Users Not Previously Known to the Service

- 3.1. When a Service User who is not known previously to services, does not have an allocated Care Co-ordinator and is receiving acute care, the acute team in question will inform the Service Users appropriate community mental health team, (NOT the local Single Point of Access Service), requesting that a Care Co-ordinator is allocated. If the acute team in question does not inform the appropriate community mental health team then that acute team will by default accept care co-ordination responsibility. Such instances will be considered as exceptions and will be managed accordingly.
- 3.2. The Community Team Manager must ensure that a **Care Co-ordinator will be allocated within two working days** and will visit the Service Users within a week. This is a responsibility of the Team Manager of the relevant team and if they do not allocate then the Care Co-ordinator will be the Team Manager by default.

4. Planning and Managing Service Users Leave from In-patient Care:

- 4.1. All periods of leave should be planned as part of a Service Users discharge plan, therefore a discharge plan should be formulated as soon as is reasonably possible and certainly before a Service User goes on leave. Naturally **all such plans must involve the Service Users Care Co-ordinator and this applies to all Service Users** whether or not they are in hospital under a section of the Mental Health Act.
- 4.2. On admission all Service User’s accommodation status will be assessed, looking particularly the security of their accommodation (tenancy, mortgage repayments etc) and what arrangements need to be made to secure their accommodation for the period of hospital admission. If homelessness is indicated as a potential delay to a Service Users leave or discharge then this should be addressed as soon as possible and local accommodation support arranged.
(See “Standards for Care Planning and Delivery for Acute Mental Health Wards”)
- 4.3. When an inpatient Service User has accrued 7 days or 168 hours leave, which may be made up of several separate leave periods, then the in-patient Acute “Keyworker” or “Named Nurse” should arrange for the multi-disciplinary team (including the Service User and their Care Co-ordinator) to formally agree a discharge plan. This plan should ideally include a discharge date. Any exceptions to this are to be

clearly documented in the Service User's notes. (A "days leave" is a period of leave that includes an overnight period). This standard helps ensure compliance with the MHA code of Practice Guidelines around the use of Section 17 leave (Department of Health, 2008).¹

- 4.4. The reason this applies to accrued leave is to ensure leave is used positively and to discourage repeated periods of leave that have no justification in terms of benefits to the client or the use of leave as a response to raised occupancy levels in hospital.
- 4.5. As part of planned leave from a ward arrangements should be made for the Service User to be seen at home within 72 hrs of the start of their leave. It is the responsibility of the Care co-ordinator (or the Home Treatment Team Key Worker) to provide a progress report to be communicated to the ward staff within 72 hours of the service User first going on leave. The Service Users' progress is to be recorded in all of their current case notes and communicated as appropriate. Whilst a "single set of notes" are recommended clients notes are often made up of separate in-patient based and community team notes, in which case progress must be communicated by both the ward and the community team and recorded in both sets of notes.
- 4.6. In order to ensure that a Service User's progress during leave is properly communicated to all staff then Standard 2.1 still applies without exception during a leave period, that is, the Care Co-ordinators contact with the Service Users and their Acute "Keyworker" or "Named Nurse" will continue throughout a leave period.

5. Planning and Managing Service Users Discharged from In-patient Care:

- 5.1. To meet the 7 day discharge standard, prior to discharge **the Service Users will be informed who will be visiting them and when and where the visit will take place.**
- 5.2. The follow up contacts for Service Users who are discharged on a Friday and are considered to need a 48 hour follow up, must be planned with and provided by the appropriate CRHT, or other team providing Service Users support at the weekend.²
- 5.3. ALL Service Users must receive a face-to-face follow up contact within seven days of their discharge. This is because any Service User who has received a period of acute care must receive an appropriate level

¹ Note: This will require regular management information about the accrued length of leave to be gathered for each Service User and should be monitored with exceptions being reported as identified within Explanation of terms document (paragraph: 3.7)

² Note: It may be necessary to monitor and manage the number of people who are discharged from hospital on a Friday or at the weekend. Whilst this may be preferable when the service users family / carers may be more able to support the leave period, it cannot be assumed as the common or default practice which would therefore have to be supported by the CRHT Team rather than the service users CMHT.

support following discharge usually involving more than one team or individual worker.³

³ Note: Typically this has indicated an “enhanced” level of care as described by the Care Programme Approach; however from October 2008 the terms “standard” and “enhanced” will no longer apply. In fact from October 2008 the system of co-ordination and support for this group only will be called the Care Programme Approach (CPA).

*Refocusing the Care Programme Approach,
Policy and Positive Practice Guidance,
Department of Health, March 2008*

References

Department of Health, 2002 "National Service Framework Policy Implementation Guidance". Department of Health

National Institute of Mental Health (England), 2004 "Crisis Resolution & Home Treatment". CSIP.

Healthcare Commission 2007, Acute Inpatient Mental Health Service Review

Department of Health 2008, Mental Health Act 1983 Code of Practice, (page 256 onwards). Department of Health