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## CRISIS RESOLUTION AND HOME TREATMENT TEAM OPERATIONAL POLICY

<b>Reference No:</b>	UHB 159	<b>Version No:</b>	1	<b>Previous Trust / LHB Ref No:</b>	N/A
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<b>Documents to read alongside this Operational Policy</b>	CMHT Operational Policy
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<b>Classification of document:</b>	Mental Health Policy
<b>Area for Circulation:</b>	Mental Health Division
<b>Author/Reviewee:</b>	Senior Nurse Manager for Crisis and Liaison Services
<b>Executive Lead:</b>	Director of Public Health
<b>Group Consulted Via/ Committee:</b>	Crisis Services Steering Group Mental Health Policy Group
<b>Approved by:</b>	Mental Health Quality and Safety Committee
<b>Date of Approval:</b>	12 December 2012
<b>Date of Review:</b>	12 December 2015
<b>Date Published:</b>	31 January 2012

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<b>Version Number</b>	<b>Date of Review Approved</b>	<b>Date Published</b>	<b>Summary of Amendments</b>
1	12/12/2012	31/01/2013	New Policy

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## **1. INTRODUCTION**

The Crisis Resolution Home Treatment Team will provide a flexible, responsive and integrated service to adult mental health clients and their carers in the most appropriate setting.

The service consists of the North CRHTT (covering Pendine, Gabalfa and Pentwyn CMHTs), the South CRHTT (covering Links, Hamadryad, Hafan Dawel, and Amy Evans CMHTs), the Crisis Recovery Unit (appendix 1) and the Crisis House (appendix 2).

The Crisis Resolution Home Treatment Teams (CRHTT) aim to provide a service for adults who appear to have severe and enduring mental disorder, and who are experiencing acute psychiatric mental health crisis that would otherwise require admission to a mental health adult inpatient facility. The CRHTT will provide a 24 hour service promoting a multidisciplinary approach whilst focusing on psychosocial needs of clients and their carers.

The CRHTT will promote continuity and consistency of care and intervention for clients and carers, offering a range of approaches and skills usually for no more than 8 weeks. If CRHTT input is indicated beyond this, weekly CPA meetings between CRHTT, the client, and the CMHT/GP should take place to ensure the right focus of care.

The CRHTT will treat each person as a unique individual who will receive non-judgemental care that sustains dignity, respect and privacy.

## **2. WHAT IS THE SERVICE INTENDING TO ACHIEVE?**

**2.1** People experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives. Home treatment can be provided in a range of settings and offers an alternative to in-patient care. The Crisis Resolution Home Treatment service will:

- Act as a gateway to Mental Health in-patient services, rapidly assessing individuals with acute mental health problems and facilitating referrals to the most appropriate service if necessary.
- Provide rapid, responsive multidisciplinary, community based treatment 24 hours per day, seven days a week, for individuals experiencing mental health problems.
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment, as close to home as clinically possible.
- Provide intensive treatment in the community as an alternative to in-patient care.
- Remain involved with the client until the crisis has resolved and the client is linked to ongoing care if required.
- Be actively involved in discharge planning and provide intensive care at home or other appropriate location (for example the Crisis House) to facilitate early discharge, when in-patient care has been necessary.

- Provide psycho-education to reduce client vulnerability to crisis and maximise their resilience.

**2.2** The service is most appropriate for those with serious mental disorder that would otherwise lead to admission to an adult inpatient mental health bed. There is no blanket exclusion based on diagnosis alone; each individual client will be assessed on the basis of clinical presentation at the point of assessment.

**2.3** The CRHTT expects to care for approximately 25 people at any one time, but the number of people receiving home treatment will be determined by capacity within the CRHT, the degree of risk/acuity of the service user and the impact upon the carer.

### **3. HOURS OF OPERATION**

The Crisis Resolution Home Treatment Team will operate 24 hours a day, 365 days per year. This will be achieved through shift work.

### **4. CATCHMENT POPULATION**

**4.1** The South Crisis Resolution and Home Treatment Team will be responsible for clients registered with a GP Practice currently aligned with the Hamadryad CMHT, Links CMHT, Hafan Dawel CMHT and Amy Evans CMHT. The North Crisis Resolution and Home Treatment Team is aligned to the Pendine CMHT, Gabalfa CMHT and Pentwyn CMHT.

**4.2** If a GP cannot be identified or if the client is registered with the Safe Haven Practice, the client's address (including hostels) will be used to determine the responsible CMHT, and subsequently the relevant CRHT.

**4.3** If an individual address cannot be identified or the individual is not a Cardiff and Vale resident, the Consultant Psychiatrist identified on the NFA Rota will have responsibility for any action required, and the corresponding CRHTT will facilitate any necessary assessment. The Shift Co-ordinator based at Whitchurch Hospital will identify which Consultant is next on the Rota.

### **5. REFERRAL PATHWAYS**

It is imperative that sufficient information is made available to the CRHTT to enable them to plan appropriate intervention with particular consideration to issues relating to risk assessment, gender preference and specific clinical information. If a full risk assessment has been undertaken it is imperative that this be available to the CRHTT. The CRHTT will make a decision on the appropriateness of the referral based on the information given. They may request further information before proceeding, they may signpost to other services or they may accept the referral as appropriate for an assessment.

#### **5.1 In Hours**

**5.1.1** During the hours of 9.00am to 5.00pm the referral should ordinarily be via the CMHT. However it is acknowledged that other mental health services such as Liaison Psychiatry, Community Addictions Unit, and the Diversion at Point of Arrest Service, may see clients who, in their professional judgement, require an admission assessment. In these circumstances the CRHT will **not** require for the referral to be seen by the CMHT first, as long as a qualified mental health professional in the relevant team has seen the client that

day. Good practice would suggest that the referrer discusses the possibility of a CRHTT referral with the CMHT, prior to making the referral.

**5.1.2** New/urgent cases will have an initial screening assessment by the CMHT duty worker to determine whether the Crisis Resolution Home Treatment Team is required.

**5.1.3** Any new referral from a CMHT **must** have been assessed face to face by the CMHT / Duty Worker / or significant other e.g. Responsible Clinician within the last 24 hours.

**5.1.4** All clients with a previously agreed Direct Access Plan in their Crisis/Contingency Plan will have access to the CRHTTs without a preliminary external assessment (See Appendix 3 for Direct Access Protocol). However in-hours it would be expected that this is discussed with the Care Co-ordinator in the first instance.

**5.1.5** All referrals will be screened by the CRHTT Duty Worker and allocated to the most appropriate discipline to assess.

## **5.2 Out of Hours**

**5.2.1** During the hours of 5.00pm and 9.00am the referral may be via the GP, the Poisons Unit, the Emergency Unit, or the Police.

**5.2.2.** Waking night shifts are staffed by one nurse from the North and South teams based at Whitchurch Hospital. Please see Appendix 4 for Night Shift Protocol

**5.2.3** All clients with a previously agreed Direct Access Plan in their Crisis/Contingency Plan will have access to the CRHTTs without a preliminary external assessment as above.

**5.2.4** In order to refer to the CRHTT, Out-of Hours GPs will need to have seen the client within the last 24 hours in order to ensure, as far as possible, that the client is physically fit for a potential psychiatric admission.

## **6. ASSESSMENT**

**6.1** The CRHTT will participate in all assessments, when admission to in patient care is a possible outcome, and for all clients requiring a Mental Health Act assessment.

**6.2** The CRHTT will provide a response to a request for an emergency assessment as soon as possible. The Welsh Assembly Government sets a CRHTT response time target of 4 hours.

**6.3** The CRHTT will determine the safest place to undertake the assessment which may include the home, CMHT, EAC at Whitchurch/Llandough Hospitals, a police station or Safe Haven.

**6.4** For clients requiring a Mental Health Act assessment, the AMHP in the sector CMHT will decide whether or not they can accommodate the MHA assessment, whether **known or unknown** to services.

It is expected that the CMHT AMHP will undertake the assessment. If, however, this is not possible, they will ascertain if the CRHT has an AMHP on duty, and will ascertain if the

CRHT AMHP is able to undertake the assessment. If that is not possible, the CMHT AMHP will discuss the assessment with the Duty Manager of the on-call rota.

If the CRHTT are not undertaking the AMHP function, a qualified member of staff from the CRHTT will attend the assessment with the CMHT AMHP, in order for the Home Treatment option to be considered. If the CRHTT are not able to attend a Mental Health Act assessment at the time planned by the CMHT, this will not delay the assessment for the client. The assessment will proceed without the CRHTT on the understanding that the assessing team will complete all relevant paperwork. If the assessment results in an admission, without the CRHTT having undertaken a gatekeeping assessment, the admission ward will inform the CRHTT of the admission in order for the CRHTT to undertake a follow-up assessment within 24 hours.

**6.5** For clients requiring an assessment as a result of a Section 136 arrest, the CRHTT administrator/duty worker, in hours Monday to Friday, will be informed of the requirement for the assessment. If a CRHTT doctor is available to undertake the assessment, the administrator will then determine if the CRHTT AMHP is available. If the CRHTT doctor is not available, the assessment defaults to the Duty Consultant. If the CRHTT AMHP is not available, firstly the CMHT AMHP will be asked if they can undertake the assessment. If the CMHT AMHP is not available, the Duty Manager for Social Services will contact the Duty AMHP. Once the assessment time is agreed, the CRHTT will then communicate all relevant details to the acute shift co-ordinator at Whitchurch Hospital. The CRHTT will not need to provide a CRHTT worker to gate-keep the assessment if the doctor or AMHP is from the CRHTT.

**6.6** The police may refer persons in their custody to the Forensic Medical Examiner (FME) or Diversion at Point of Arrest nurse (DAPA), if they are concerned for their mental health. If the FME or DAPA nurse judges that the person may need an adult mental health admission, they will liaise with the CRHTT about the most appropriate venue for the assessment. If the criminal justice procedures are concluded, and there is no risk factor to prohibit this then the CRHTT may decide to assess the client at home. The CRHTT may feel the assessment requires medical input, in which case they will liaise with the junior doctor to co-ordinate an assessment at EAC/Llanfair as per GP referrals. Sometimes, however, the assessment will need to take place at the police station because the client is deemed too risky (in terms of their mental health) to be released in which case a senior doctor would need to be involved in the assessment with the CRHTT. This will only apply to persons requiring an informal assessment.

**6.7** The assessment will, as a minimum, consider:

- The presenting problem (what has happened to precipitate action now)
- Risk issues
- Accommodation status
- Clinical signs and symptoms
- Unsafe or intolerable behaviour (this is most likely to cause community treatment breakdown)
- Carers and dependant children's needs including names and date of birth of all under 18 year olds as per 'Safeguarding Children Guidelines'.
- Interpersonal relationships
- Social support and needs
- Willingness to cooperate

**6.8** The assessment will actively involve the client, carer/family and all relevant others e.g. GP, Care Co-ordinator if appropriate.

**6.9** The assessment will be multidisciplinary where possible, and will identify the client's needs and levels of risk. "All clients assessed at any point of their contact with secondary mental health services must have a risk assessment completed" (Welsh Assembly Government 2010).

The FACE risk profile (PARIS form 4) will be used as a baseline risk assessment tool for all clients in contact with the CHRTT. Further risk assessment tools may be used if the practitioner is suitably qualified, including the WARRN formulation aid.

"The findings of any tool based assessments must be combined and balanced with information on any other aspects of the person's life and current situation (DoH 2007)".

**6.10** Any physical health assessments will be carried out if relevant. It may be necessary to request the GP to review the physical health status of the client.

**6.11** Once the CRHTT is involved in an assessment, they will remain involved and responsible for the immediate care needs of the client until a clinical decision is reached regarding the future management and care and, if required, a successful transfer has been carried out.

**6.12** 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 is aware of any outstanding/unmet needs.

**6.13** For a CRHTT assessment to be concluded, one of the following options must have been achieved:

- A CRHTT care plan is in place.
- The client has been admitted to hospital or other appropriate agency.
- Acute intervention is not required but other appropriate support from other parts of the service is organised/will be organised.
- No further action or intervention is required from Secondary Mental Health Services.

**6.14** If an assessment is required under the Mental Health Act, the AMHP has a responsibility, in line with the Code of Practice, to manage the process. As such the CRHTT will actively participate until they are no longer required.

**6.15** If a known client is accepted by the CRHTT out of hours, the CRHTT will contact the care co-ordinator the next working day to agree a plan of care. Alternatively an out of hours assessment may not require home treatment, but is suitable for further assessment at the CMHT. In this instance, the CRHTT will inform the CMHT as soon as practicable, detailing any further action or recommendations for follow-up.

**6.16** CRHTT Administrators will fax a notification to the GP the next working day highlighting whether the client was admitted, detained or sent home. CRHTT clinical staff will fax a full summary within ten days.



## **7. IN PATIENT ADMISSION CRITERIA**

As recommended by the Sainsbury Centre for Mental Health (2001), the main indicators for hospitalisation are:

- Disorganised and aggressive behaviour from someone who refuses to co-operate, even after much persuasion by a team or members of his / her social network.
- Psychological disturbance of a nature too extreme to be tolerated outside a contained hospital environment.
- Excessive use of drugs and / or alcohol, particularly where the client cannot safely be treated by detox at home, as continued substance misuse will interfere with the treatment of his or her mental illness.
- The person presents a danger to others, which is not going to change and requires containment.
- Persistent acting out behaviour, or the threat of it, indicative of borderline personality disorder, even after protracted discussions with team members.

**7.1** Clients will be admitted when an application for compulsory admission has been completed.

**7.2** When a Responsible Clinician (RC) intends to use powers of recall as per Community Treatment Order. Please see Appendix 5 for Recall of CTO protocol.

**7.3** Should the client refuse the involvement of the CRHTT, admission will only be offered if clinically indicated. This would be discussed with the care co-ordinator at the earliest opportunity. Should the client's support network break down, the CRHTT will first need to consider all other options first, such as the Crisis House.

## **8. CARE PLANNING**

**8.1** If a period of Home Treatment is indicated, the Care Co-ordinator will retain responsibility for the client. The Care Co-ordinator will usually be a member of staff from a CMHT, however, care planning will be shared by the CRHTT named worker and the Care Co-ordinator, if appointed.

**8.2** 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. The CRHTT will regularly communicate progress to inform CMHT discussions regarding future needs.

**8.3** The CMHTs will prioritise CRHTT clients, along with current in patients, for allocation of a Care Co-ordinator as soon as possible.

**8.4** Care planning within the CRHTT will be led by the named worker, but will require a whole team discussion and agreement. The outcome will be a focused care plan detailing:

- The objectives to be met, including practical intervention in all areas as necessary to achieve the resolution of the current crisis.
- The number and frequency of visits. This needs to be flexible enough to respond rapidly to changes in the clinical situation.
- The CRHTT plans for medication administration, whether the client is obtaining them from the GP thereby self-administering, whether the CRHTT are prompting the

client to take their medication, or whether the CRHTT are administering the medication.

- Positive risk taking strategies, to include what are the risks, what are the CRHTT doing to ensure the risks are managed and what is the expected outcome of the CRHTT involvement (Steve Morgan, 2010).
- Care planning will require the active involvement of the client, taking account of the views, input and concerns of family/carers. Clients and carers will be provided with contact numbers and advised how to access the CRHTT urgently.
- Care planning involves actively planning for the discharge from the CRHTT at an early stage in the process.

**8.5** Care plans will be reviewed as required, but no less than weekly at a designated CRHTT multidisciplinary team meeting. CRHTT care plans are accessible to care co-ordinators via Paris, however it is expected that the care co-ordinator will remain actively involved in care delivery whilst the client is under the care of the CRHTT. As a minimum this would include weekly liaison with the team and at least one formal CPA review before discharge/handover from the CRHTT. There is evidence to suggest that joint working improves outcomes for patients (Sesay 2008) therefore joint visits where possible will inform care planning.

## **9. INTERVENTION**

**9.1** Services will be provided at the client's place of residence or when this is not a suitable location, they will be provided at the Crisis House for 24 hour support, or at the Crisis Recovery Unit for day time support.

## **10. RESOLUTION**

**10.1** Planning for discharge from the CRHTT will begin early. The CRHTT will advise the client and their carers that the purpose of Home Treatment is enable the client to return to their usual level of functioning as soon as possible.

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

- There is a good shared understanding why the crisis occurred and what is required to avoid a re-occurrence.
- Coping strategies have been explored with the client and their family/carer.
- A summary of input is provided to the referrer, including successful strategies to assist the care co-ordinator in developing a Crisis/Contingency Plan. For clients discharged to the GP, the CRHTT will devise the Plan. In all cases, a discharge summary will be faxed to the GP and recorded on Paris within 48 hours.
- If ongoing care is provided by the Care Co-ordinator then a discharge planning meeting to confirm the details of on-going needs should take place prior to discontinuation of the CRHTT, attended by CRHTT, the Care Co-ordinator and all relevant professionals. CMHT Operational Policy states that follow up will then be provided within 5 working days of discharge from the CRHTT.
- The client and his/her family/carer have had an opportunity to comment on the service they received and contribute to service improvement.

## 11. LINKS WITH IN PATIENT SERVICES

**11.1** The CRHTT will work collaboratively with in patient staff at all stages of in patient care as one of their core functions. Where possible a representative of the CRHTT will attend the relevant wards on a daily basis to review in-patients' progress towards discharge, providing advice to the ward team on what needs to change for the CRHTT to be able to re-consider Home Treatment.

**11.2** 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, Care Coordinators, Responsible Clinicians and CRHTT staff.

**11.3** The CRHTT will identify all relevant reasons for admission and what needs to change during inpatient stay in order for home treatment to become a viable option. This will be identified on the CP1A Assessment Outcome box.

**11.4** Progress towards discharge will be monitored through joint care review meetings between in patient and CRHTT staff. These meetings will focus on the reasons for admission and will identify a planned discharge date.

**11.5** The CRHTT will support clients at home who are subject to Section 17 Leave, if indicated.

## 12. LINKS WITH PERI-NATAL SERVICES

**12.1** The CRHTT is not ordinarily required to act as a gateway to inpatient beds at the Mother and Baby Unit as the Service is a specialist provision. However, the CRHTT **WILL** assess clients known to the Peri-Natal Service **in hours** if, after prior discussion with the Peri-Natal Team it is felt safe and appropriate to consider home treatment. The Peri-Natal Service will joint-work with the CRHTT throughout any spell of home treatment.

**12.2 Out of hours**, emergency admissions to the Mother and Baby Unit are not generally appropriate but there may be occasional exceptions when this is indicated. If the CRHTT decide, after an assessment, that a Mother and Baby Unit admission is appropriate this is to be discussed with the Unit staff who are best placed to make this decision. This decision will take into account staffing levels, the needs of other clients and risk assessments.

## 13. LINKS WITH LEARNING DIFFICULTIES SERVICES

**13.1** Learning disability should not act as a barrier to acceptance by the CRHT as long as the CRHT 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 CRHT and Learning Disability Services in hours. Outside of normal operating hours, the CRHTT can access the Learning Disabilities on-call rota for advice regarding the on-going management of any client they assess who may fall into the remit of the Learning Disabilities Service.

The CRHTT is not required to act as a gateway to two of the inpatient beds at the Rawnsley Unit. These are specialist beds provided for clients of the Learning Disabilities Team who remain involved in the provision of care. If, however, the responsible team feel

there is a potential for the CRHTT to support leave/discharge for these clients, this will be jointly-assessed on an individual basis.

## **14. SUPPORT TO FORENSIC CLIENTS OUT OF HOURS**

**14.1** The CRHTT will assess clients of the Community Forensic Service **out of hours only**, ie weekends, bank holidays and evenings in the following circumstances:

- If the individual is known to the Forensic Service, and is in police custody and is deemed to need a mental health assessment by the Forensic Medical Examiner the CRHTT will attend with the on-call psychiatrist.
- If the individual is known to the Forensic Service, and is referred for an admission assessment by their GP or Mental Health Liaison Service, the CRHTT will undertake an admission assessment.

The CRHTT will **not** be required to assess clients of the Community Forensic Service in these circumstances:

- If the individual is known to the Forensic Service and has committed a major crime eg murder, they will be assessed by the Caswell Clinic.
- If the individual is known to the Forensic Service and has committed a serious crime eg arson, the police will access advice from The Forensic Team Leader or Court Liaison Nurse as the “Single Point of Contact” person. Should the “Single Point of Contact” feel a generic admission assessment is indicated, they will refer to the CRHTT to undertake an admission assessment.
- If the individual is in prison and deemed to need transfer to a hospital bed, the Forensic Service will undertake this assessment. It is expected that this would only be facilitated in hours, however if needed out of hours this will be facilitated by the on-call Senior Psychiatrist.
- If an individual, currently open to the Forensic Service needs extra support over the weekend they would be appropriately referred to the Weekend CPN Service.

**14.2** The CRHTT will access Paris records in order to undertake a safe assessment. The “risk alert” function within Paris will be used by the Forensic Service to share concerns. There are occasions when specific details are not recorded on Paris for legal reasons; this is classed as “privileged information” and may be recorded as “contact care co-ordinator” or “hidden information”. Should the CRHTT be called to assess in these circumstances, they will ring the Forensic Team Leader or Court Liaison Nurse for further details.

**14.3** It is most likely that, if a client known to the Forensic Service presents out of hours in a “crisis”, the Service would have exhausted all other avenues already and admission is the safest outcome of the CRHTT assessment. However, there will be circumstances when the CRHTT feels that home treatment is an option, until the Forensic Service re-opens. In this circumstance, the assessment outcome should be discussed with senior on-call medical staff and the “Single Point of Contact”.

## **15. INTERFACE WITH WEEKEND CPN SERVICE**

**15.1** Know clients currently requiring a higher level of support from a CMHT (but not at the point of needing admission) would usually be referred to the weekend CPN service.

**15.2** If the Weekend CPN Service identifies that the client requires Admission, a referral to the CRHTT would be appropriate.

**15.3** If a known client is assessed out of hours by the CRHTT, and is deemed to need extra support but not admission a referral to Weekend CPN would be appropriate.

## **16. MANAGEMENT**

**16.1** The day-to-day management of Nursing, Psychology, Medical, Administrative and Social Work staff will be the responsibility of the Team Leader. This includes roster planning, annual leave and sickness monitoring.

## **17. PATIENT SAFETY AND QUALITY**

**17.1** CRHTT practice will be fully in accordance with clinical governance standards to deliver a high quality service aiming towards constant service improvement.

**17.2** CRHTT staff will be trained in appropriate risk assessment and management, equipping them with the necessary skills to undertake the role.

**17.3** The CRHTT will be engaged with the Divisional patient safety and quality agenda and will follow all Adult Mental Health Directorate reporting procedures.

**17.4** The CRHTT will participate in the joint Community/CRHTT monthly Patient Safety and Quality Forum.

**17.5** The CRHTT will, in accordance with the above meeting, hold a local CRHTT Patient Safety and Quality Forum alternating venues between the North, South and CRU.

## **18. EQUALITY STATEMENT**

**18.1** Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. We wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

## **References**

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**APPENDIX 1**



**Mental Health Services**

**Cardiff & Vale  
Crisis Resolution & Home Treatment Services  
Crisis Recovery Unit**

Author	Senior Nurse Manager Community Services on behalf of Day Services Steering Group	
Policy ratified by		
Responsible Officer (Lead of Group)		
Classification		Date Issued :
Area Applicable	Trust wide	Review Date :
Ref No:		Version No: 1

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## 1. Philosophy

The Crisis Recovery Unit (CRU) provides assessment, therapeutic intervention and support, in a safe environment, for individuals experiencing a mental health crisis. It is designed to provide a flexible and responsive assessment and treatment service. The service supports clients of both Cardiff Crisis Resolution Teams, providing an intensive and consistent therapy that may not be available in a community based setting.

The service provides respite for both Service Users and Carers, reducing tension and de-escalating difficult social situations. In some circumstances it will enable carers to return to work, if necessary.

***This policy should be read in conjunction with the Operational Policy for Cardiff & Vale Crisis Resolution & Home Treatment Service.***

## 2. Mission Statement

We aim to support the tenet that people experiencing severe mental health difficulties should be treated in the least restrictive environment with the minimum of disruption to their lives by providing care and treatment at the Crisis Recovery Unit, as an alternative to in patient care.

## 3. Service Aims

The Crisis Recovery Unit will promote a relaxed, non-threatening environment for service users in crisis or following a crisis. A range of treatments and activities will be provided. Service users will collaborate in the development of individually designed treatment programmes. These programmes will provide a balance of therapeutic interventions, recreational activities and “time out” in a non-pressured setting.

It is also expected that every client will have a period of dedicated one to one time with a member of unit staff during every attendance.

**Assessments** may include:

- Observation
- Beck Depression Inventory
- Hospital Anxiety & Depression Scale
- Life Style Adjustment
- HONOS
- Daily Living Assessments
- Home Assessments
- Vocational Rehabilitation Assessment

### **Psychological Therapies**

- Cognitive Behavioural Therapy
- Relapse prevention
- 1 to 1 support
- Psycho-education
- Family/Carer support
- Anxiety Management
- Relaxation
- Behavioural Programmes
- Confidence building
- Concordance Therapy
- Medication management

## **Physical Therapy**

Physiotherapy Programmes

Walking

Gardening

Swimming

**Recreational Therapy** may include:

Music Activities

Creative Activities

Pool

Computers

Television/DVDs

Video Games

Tea/coffee

## **4. Hours of Operation:**

The service will normally operate from 9:30 am until 5:30 pm seven days a week. Hours of opening may be reduced at weekends, according to demand. Services users will attend as required, as part of a CPA Care plan.

## **5. Refreshments / meals**

Formal cooked meals would not normally be provided, but the facilities to provide snacks / refreshments will be provided free of charge. Help and support to produce these will be provided by the staff team who will be fully trained to carry out these duties.

Special diets could be sourced as required.

These points of contact are recognised as excellent opportunities for establishing rapport, assessment in “normal” situations and informal therapy.

## **6. Transport**

Transport can be offered to clients referred to the CRU as deemed clinically appropriate. This will in most instances take the form of Contract Taxis.

## **7. Catchment Population**

The CRU will offer services to individuals being treated by either of the two Crisis Resolution & Home Treatment Teams that operate in Cardiff and the Vale of Glamorgan.

The service is not normally appropriate for individuals with a primary diagnosis of :

- Mild anxiety disorders.
- Primary diagnosis of alcohol or other substance misuse.
- Brain damage or other organic disorders including dementia.
- Learning disabilities.
- Exclusive diagnosis of personality disorder. ??
- Recent history of self-harm, but not suffering from a psychotic illness or severe depressive illness.
- A crisis related solely to relationship issues.

Attendance at the CRU will be subject to a risk assessment. Clients will not be permitted to consume alcohol or illicit substances whilst attending the service.

In the event of a service user using offensive or unacceptable behaviour, continued attendance at the unit will be subject to a CPA review.

## **8. Number of Service user attendances**

The unit will have a maximum fifteen places per day. This figure will be subject to review. The number of places available at any one time will also be dependent on the acuity of individuals receiving services at that time.

The maximum length of treatment programmes will be as defined in the operational Policy for the CRHTT.

## **9. Organisational Structure**

The CRU staff team will be drawn from a range of mental health disciplines.

Managerial responsibility for the CRU will be within the remit of the Senior Nurse Community. A CRU manager will be responsible for the day to day running of the service.

Certain grades / disciplines at the CRU will be encouraged to participate in a rotational programme that may involve placement within the CRHTS.

Staff with a special responsibility for the development of activity programmes will be identified. Other staff will also be tasked with the administration of clerical duties

Medical input to the CRU will be provided by the CRHTS Teams. For further discussion

## **10. Operational Relationships**

The CRU is an element of the Crisis Resolution and Home Treatment Service. Clients can only be accepted into the CRU via the CRHTS.

There will be no waiting list or referral system. The CRU and the CRHTT will provide a fully integrated service. The CRU will provide a “same day” service, to enhance both the quality and flexibility of care.

In the event of all 15 places being used, the CRU manager will liaise with the Team Leaders of the CRHTT to facilitate patient throughput. It is the responsibility of the CRU manager to alert key personnel both within the Crisis Service and in the General Mental Health Directorate in the event of full service utilisation. The CRU can extend its client population, in extremis and over a limited 24hr period, to 16.

## **11. Formal CPA Reviews and Risk Assessment**

The Crisis Recovery Unit will adopt the Crisis Resolution and Home Treatment Team model of CPA.

Care Coordination remains with the Neighbourhood CMHT. CRHT's will assume keyworker responsibility of clients whilst they attend the crisis service, CRU staff will assume the role of associate workers .

For clients new to the service, for whom their first contact is with the CRHTS, the crisis team will assume the Care Coordination role. It is therefore the responsibility of the neighbourhood CMHT to arrange, monitor

and coordinate the CPA Review process. An essential element of this process is Risk Assessment. This will be coordinated as described for the CPA above.

The CRU is to be a considered a community based resource. The management of Psychiatric and Medical Emergencies will be subject to existing Trust policies for community services.

## **12. Clinical/Operational Review Process**

Clients attending the Crisis Recovery Unit will be reviewed daily at staff “handover”.

A multi-disciplinary team meeting will be held weekly. All clients receiving services from the CRU will be discussed at this meeting. Representatives from the CRHTS and the neighbourhood CMHT will attend this meeting.

## **13. Audit and Performance Management System**

Audit arrangements will be the same as that established for the Crisis Resolution & Home Treatment Team. This includes a measure of User/Carer satisfaction, together with statistical information on service usage.

The CRHTS reporting mechanism will be used to provide regular management reports.

## **14. Staff Team**

Band	Title	Number (wte)
7	CRU Manager	1
7	Head Occupational Therapist	0.5
6	Deputy Nurse Manager	1
5	Mental Health Nurse	3
5	Rotational Basic Grade Occupational Therapist	1
4	Physiotherapy Technician	0.4
3	Community Support Workers	4
3	Occupational Therapy Tech 3	2

## **APPENDIX 2**

### **OPERATIONAL POLICY**

#### **CRISIS HOUSE**

##### **1. Philosophy**

The Crisis House will provide short term crisis accommodation for adult clients with severe and enduring mental illness who are experiencing crisis in their mental health. The project will seek to provide a holistic approach to aiding recovery. The service aims to prevent the possible stigmatization of hospital admission. The creation of a safe, comfortable and supportive environment that is responsive to individual need is essential to an individuals' recovery. The Crisis House will provide a 24 hour service staffed by Support Workers employed by Gofal Cymru and will be supported by the Crisis Resolution & Home Treatment Teams.

The Crisis House will promote continuity of care between itself and community based services, focusing on the psychosocial needs of service users for a maximum of 7 days.

##### **2. What is the service intending to achieve?**

- People experiencing severe mental health difficulties should be supported in the least restrictive environment with the minimum of disruption to their lives.
- The Crisis House will only be accessed via the Crisis Resolution & Home Treatment Teams who will act as 'gatekeeper' to the service
- Provide intensive support to clients in the Crisis House as an alternative to inpatient care.
- To provide practical and emotional support to individuals who are experiencing an acute psychiatric crisis.
- **Facilitate early discharge from hospital via the Crisis Teams**
- Be actively involved in care planning to facilitate a return to the individual's home.

##### **3. Criteria for admission to the Crisis House**

The Crisis House will accept only those individuals currently under the care of the Crisis Resolution & Home Treatment Teams. In order to focus services on those with the highest level of need, the Crisis House is less likely to offer intensive support to individuals suffering with:

- Mild anxiety disorders
- Primary diagnosis of alcohol or other substance misuse
- Brain damage or other organic disorders including dementia.
- Learning disabilities.
- Exclusive diagnosis of personality disorder.
- Recent history of self-harm, but not suffering from a psychotic illness or severe depressive illness.
- A crisis related solely to relationship issues.

There is no blanket exclusion on these groups and each individual case will be considered on its merits and assessed by the Crisis Resolution & Home Treatment Team staff.

#### **4. Hours of Operation**

The project will be staffed 24 hours per day with support workers covering both day and night-time shifts plus sleep-ins. The project co-ordinator will mainly cover daytime shifts but will cover night-time shifts and sleep-ins to cover annual leave and sickness. The project will aim to provide two members of staff on a twenty-four hours basis. Where this is not possible lone cover will take place during day-time hours with on-call support from both the regional office of Gofal for line management support and the Crisis Resolution and Home Treatment Teams for clinical/medical support.

The project will seek to maintain a relief bank. This will include existing employees and others known to the organisation in an effort to maintain consistency and standard of care/support.

#### **5. Referral**

- Individuals will only be admitted to the Crisis House once they have been assessed and taken on by the Crisis Resolution & Home Treatment Team.
- A verbal referral will be taken by Crisis House Staff, accompanied by a current CPA risk assessment. Referral information sought by the project will include
  - What is the crisis?
  - Any changes in behaviour thoughts or feelings?
  - Professional diagnosis
  - Anticipated input from the CRHTT
  - Does the service user/carer/relative agree to the referral to the house?
  - Mental health related admissions
  - Current prescribed medication
  - Are there signs that indicate their mental health is deteriorating?
  - Does the service user have a care plan (CPA)?
  - What do they need to support them through this crisis?
  - Are there any cultural or religious needs relevant to using the service?
  - Are there any physical or health needs relevant to using the service?
  - Social issues e.g. homelessness
- The project is staffed via lone-waking cover between the hours of 11pm and 8pm. Referrals made during these hours will only be accepted for individuals known to Trust services prior to day of referral.
- Where service users are identified as experiencing significant health issues they will be supported in temporary registration with the local General Practitioner.
- Within twenty-four hours of intake a secondary assessment will be carried out in order to inform a support/action plan for the duration of the stay. Where a service

user is subject to enhanced CPA discussion will be held with the CRHTT and, where possible, the care co-ordinator in order to ensure consistent delivery of care and support. This will also provide information on existing care plans upon the service users return home.

- Individuals referred to the scheme will be residents of Cardiff and the Vale of Glamorgan. Where any person referred is homeless or of no fixed abode this information will be provided at point of referral. Crisis house staff will seek to engage other agencies in order to address housing need from the commencement of stay.
- Particular consideration will be given to issues relating to risk assessment, gender and current mental health issues.

## **6. Assessment**

The Crisis Resolution & Home Treatment Teams will act as 'gatekeeper' to the Crisis House beds. All assessments will be undertaken by a qualified nurse, social worker or doctor based in the Crisis Resolution & Home Treatment Teams. The assessment will, as a minimum, consider:

- The presenting problem
- Risk issues
- Accommodation status
- Clinical signs and symptoms
- Carer's and dependant children's needs
- Interpersonal relationships
- Social support and needs
- Willingness to engage with services

Assessment to the Crisis House will actively involve the client, Carer/family, Crisis House staff and all relevant others, e.g. GP, Care Co-ordinator if appropriate

Levels of risk will be identified and needs to be sensitive to increased risks due to alcohol or substance misuse.

Risk assessment and management will form a key function of the Community Crisis House. In addition to an initial risk assessment provided at the point of referral, risk will be reviewed on a daily basis and information communicated at handover of shifts between support workers. Any change or new observation in relation to risk will be communicated to the Crisis Resolution and Home Treatment Teams. Where significant observations are made indicating immediate risk to self or others, advice will be sought from the CRHT and reported to line managers. If out of office hours, use will be made of both on-call within Gofal and CRHT.

It will be the responsibility of the project co-ordinator in conjunction with the Service Manager and CRHT to regularly review mechanisms for the assessment and communication of risk

## **7. Support Planning**

The Care Co-ordinator will retain overall responsibility for the client and will usually be a member of staff from a Community Mental Health Team, however, care/support planning will be shared by the Crisis House, Crisis Resolution & Home Treatment Team named worker and the Care Co-ordinator where appropriate.

It is anticipated that discussion of support to be provided will have been held between the service user and key-worker in the CRHTT prior to reception in the crisis house. The initial engagement with CRHTT will form the basis of support provided in the crisis house. Within 48 hours of arrival the service user will agree a support plan with Crisis House staff. This will be reviewed regularly and discussed by Support Workers during hand-over of shifts. Where possible, Support Plans will be agreed in discussion with the key worker in the CRHTT and, where appropriate, with their care co-ordinator. The support plan is intended to compliment the service users overall statutory care plan where one is in place.

### **Crisis House Staff will draw up a focused support plan detailing**

- (i) The Objectives to be met
- (ii) The interventions offered to the individual detailing by whom, when and where the intervention will take place.
- (iii) Support planning will require the active involvement of the client, taking account of the views, input and concerns of family/carers.
- (iv) Support planning will involve actively planning for the client to return home within 7/14 days

Support plans will be reviewed as required, but within 4/6 days of initial agreement of the plan.

The Crisis Resolution & Home Treatment Team will remain involved throughout the period that accommodation is required in the Crisis House.

## **8. Record Keeping**

It is anticipated that a shared record keeping system will be maintained between the Crisis House and CRHTT via the Trusts' PARIS system. The CRHTT will ensure that as part of the assessment process Form 2a of the CPA (Consent to share information) has been agreed with the service user.

## **9. Move-on / Eviction**

The project will seek to evict people whose behaviour becomes incompatible with the ability to maintain the safety of staff and other residents unless it is a direct result of the individual's mental health difficulties, in which case an inpatient admission may be sought. Service users will be advised of this on reception to the project or as soon as possible after their arrival.

Individuals will be able to stay in the Crisis House for a period usually of seven days but up to a maximum of 14 days based upon clinical need. In cases likely to extend beyond seven days care and support will be reviewed jointly by Crisis House and CRHTT staff. Following this, individuals will be expected to return to their home. If this is not possible the Local Authority will be approached to provide short-term accommodation. The Crisis House staff,



CRHTT and Care Co-ordinator will be responsible for ensuring continuity of care throughout the move on period.

**10. Alcohol / Substance Misuse**

Alcohol or illegal substances will not be permitted in the Crisis House. Clients will be asked to agree to a contract not to misuse alcohol or illegal substances whilst resident in the Crisis House. Should a resident exhibit behaviour which places others at risk, they will be asked to leave the Crisis House.

**11. Medication**

The CRHTT will assume responsibility for ensuring that the client has the necessary medication. Each bedroom will have a locked box to store individual medication; the key will be kept in the Crisis House office in order to ensure the safety of other residents and the availability of the key/box as new residents use the Crisis House facility. Medication will be supplied by the CRHTT and will either be administered by CRHTT staff or the client. It is not the responsibility of Gofal staff to administer medication.

**12. Staff Support, Supervision and Management**

Staff and the project will receive regular supervision in line with Gofal policy and procedure. Direct supervision and day to day advice will be provided by the project coordinator with formal line management and supervision provided by the Service Manager.

**13. Grievance and Complaints**

Both grievances and complaints will be guided by Gofal Policy and Procedure. Copies of these policies will be available at all times to both staff and users of the service. Service users will be made aware of complaints procedures on entry to the project.

**14. Service User Involvement and Consultation**

The views and needs of service users will form a central consideration in the ongoing development and delivery of the service in the crisis house. A variety of strategies will be employed to engage service users including exit questionnaires, focus groups involving former residents of the Crisis House and consultation with existing service user involvement groups. It is also hoped that service users will be involved in the Project Advisory Group (see below)

**15. Project Advisory Group**

A multi-agency project advisory group will be formed in consultation with the joint operational group (mental health). This group will consist of service users as well as statutory and voluntary providers of mental health services. Chaired by Gofal, the group will act as a point of reference in discussions on the operation and development of the Crisis House.

**APPENDIX 3**

**Cardiff and Vale University Health Board  
Mental Health Service Group  
Adult Directorate - Community**

**Protocol for Direct Access to the Crisis Resolution and Home Treatment Teams**

**Purpose**

The purpose of this protocol is to support a prompt and effective response to those patients who experience a rapid deterioration in their mental health.

**Background**

A large number of patients under the care of the mental health services have a chronic mental illness. Care and treatment is delivered through Community Mental Health Teams (CMHTs), under the Care Programme Approach (WAG, 2005). All these patients should have a Care Plan which is subject to regular review and many of these patients are likely to be in receipt of an Enhanced level of care.

The development of Crisis Resolution & Home Treatment Teams (CRHTTs) means that patients who would previously have been admitted to hospital, if their mental health deteriorated to a point where they could not be safely supported by the CMHT, are now offered intensive Home Treatment as an alternative to admission.

Whereas the CMHTs are open 9.00 am – 5.00 pm Monday to Friday, with a weekend Community Mental Health Nurse service at weekends and Bank Holidays, the Crisis Resolution & Home Treatment Teams function 24 hours a day, throughout the year.

**For whom is Direct Access appropriate?**

Part of the role of CMHTs is to help patients to identify their signs of relapse and to develop relapse prevention and crisis plans. These plans should involve making contact with their Care Co-ordinator, or other professionals involved in their care, if the patient identifies that they are suffering signs of a relapse in their mental illness. Normally, this would be done within the hours of 9.00 am – 5.00 pm.

It is acknowledged that there are some patients who, for whatever reason, experience very rapid relapses in their mental illness. It is proposed that these patients should have Direct Access to the CRHTTs out-of-hours (5.00 pm – 9.00 am) as part of their Care Plans.

**What is Direct Access?**

Patients with Direct Access will be given the telephone number of the relevant CRHTT to use if they are in need of urgent advice or support out-of-hours.

If contacted by a client who has Direct Access out-of-hours, the CRHTT will decide whether to give telephone advice only or whether to visit and/or arrange an assessment.

If the CRHTT identifies a need for additional support from the CMHT following contact from a client out-of-hours, a telephone call will be made to their Care Co-ordinator to agree a collaborative plan, including the offer of an urgent appointment as soon as is practicable, if necessary.

If an assessment is arranged by the CRHTT out of hours, the patient may be taken on by the CRHTT; they may be referred back to the CMHT; or they may be referred to the weekend Community Mental Health Nursing service. In any case, team members in the relevant CMHT will be notified on PARIS.

#### Agreeing Direct Access as part of a Care Plan

In order for Direct Access to be agreed as part of a patient's Care Plan, the CRHTT must be informed that this is being considered and invited to the CPA Review.

The CRHTT will maintain a list of those patients who have a Direct Access agreement as part of their Care Plan. This list will be circulated quarterly to the CMHT Team Administrators, for information.

#### Reviewing a Direct Access agreement

The need to continue the Direct Access arrangement will be reviewed as part of the CPA Review process.

If it is anticipated that there is a need for Direct Access to continue, the CRHTT will need to be invited to the patient's CPA Review. Direct Access may be renewed or discontinued, according to the clinical needs of the patient.

#### Protocol review process

This protocol will be reviewed by the CRHTT Team Managers after one year, in August 2009

**APPENDIX 4**

***DRAFT***

**CRHT NIGHT SHIFT PROTOCOL**

1. Handover from day staff at CRHTT base i.e. North team at Whitchurch, South team at The Hamadryad Centre at 8pm. The South Team will then base themselves with the other night workers at Whitchurch, but either team may need to undertake other work before being available.
2. The taking of referrals is the responsibility of the CRHT worker. This is to ensure the appropriate screening and consideration of workload can take place. If neither South or North CRHT worker is available, the patient details and referrer contact details can be taken by the ANP or duty doctor, and the CRHT will ring back when available to screen and accept the referral if appropriate (2-hour response time).
3. The only safe places to undertake night-time assessments are the Emergency Assessment Suite at Whitchurch Hospital, A&E UHW, and in police custody (the Llanfair Assessment Suite is not to be used after 8pm). Should a Mental Health Act Assessment be required in the community, staff are to liaise with EDT who are responsible for its co-ordination.
4. Assessments which are referred to the team after 7pm will be delayed for the night staff to perform. Assessments referred after 6am will be delayed for the early shift to perform.
5. Should either CRHT have more work than is possible to address, then it is expected that the workload is to be shared between both teams. Home Treatment needs should take priority in busy times, in order to maintain the 24 hour service to clients. It is also expected that wherever possible, both CRHTT workers will provide support to each other.
6. Breaks are 1 hour in duration. North and South CRHT workers are to stagger their breaks, and the remaining worker is to hold the phones. Should “home treatment” calls be received in the hours’ break then the available member of staff is to respond and provide support on behalf of their colleague, if possible. If a referral is received in the hour’s break the available member of staff is to screen and take the referral.
7. Staff should remain on Trust premises throughout their shift unless at a clients home or undertaking an assessment. When visiting clients off-site, staff to comply with UHB’s Lone Worker Policy, visiting double-handed and informing the Advanced Nurse Practitioner of their intended destination and expected return time.
8. Any medication required from stock may be taken from the North team providing appropriate documentation is completed.

**IN THE EVENT OF THERE BEING ONLY ONE CRHT WORKER AVAILABLE  
(SICKNESS, BEING REDEPLOYED OR WORK ELSEWHERE)....**

1. The available worker is responsible for holding the other teams’ mobile phone, taking and screening their referrals and responding to calls from clients on the “home treatment” caseload.
2. The CRHT worker will undertake assessments for BOTH teams where possible.
3. Should a “home treatment” visit be indicated CRHT to approach the ANP for staff assistance.
4. If the CRHT worker is engaged in other work when an assessment arrives at Whitchurch, it is appropriate for the ANP to receive the client at front hall, and explain the delay. In the event of more than one assessment having to take place, priority should be given to the first person to arrive, unless an emergency presentation needs to take precedence
5. Incident forms to be completed for each patient who does not receive a gate keeping assessment, or each home treatment visit that cannot be facilitated.

**APPENDIX 5**