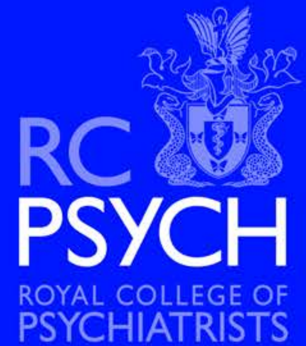

Home Treatment Accreditation Scheme (HTAS)

Standards for Home Treatment Teams – Pilot Edition

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Foreword

We are delighted to be releasing this pilot edition of the Standards for Home Treatment Teams.

The standards included have been developed in consultation with a multidisciplinary group of people involved with the work of crisis resolution/home treatment teams. This process was guided by staff from the Royal College of Psychiatrists Centre for Quality Improvement (CCQI). The names of those involved are listed overleaf and our thanks go to them for their support and input which has been crucial to the process.

These standards are for use in the pilot phase of the Home Treatment Accreditation Scheme (HTAS), which runs from April 2012 until early 2013. A final consultation on the standards will take place with the pilot teams after the pilot has ended.

The HTAS team
March 2012

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Introduction

The accreditation standards, drawn from key documents and expert consensus, have been subject to extensive consultation with professional groups involved in the provision of crisis resolution/home treatment service, and with service users and carers.

The standards have been developed for the purposes of review and accreditation as part of the Home Treatment Accreditation Scheme (HTAS), however they can also be used as a guide for new or developing services. Please refer to the HTAS Accreditation Process document for information on the process of accreditation.

The standards cover the following topics:

- Service provision and structure
- Staff, appraisal, supervision and training
- Assessment, care planning and transfer or discharge
- Interventions

In this document, the crisis resolution/home treatment team is referred to as 'the service' or 'the home treatment team'. Teams have differing titles and the standards development group agreed that 'home treatment team' captures these services most accurately.

Since home treatment teams differ widely in their configurations and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

To support their use in the accreditation process, each standard has been categorised as follows:

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;

- **Type 2:** standards that an accredited team would be expected to meet;

- **Type 3:** standards that an excellent team should meet or standards that are not the direct responsibility of the team.

The full set of standards is aspirational and it is unlikely that any team would meet them all. In order to achieve accreditation, a team must meet 100% of type 1 standards, 80% of type 2 standards and the majority of type 3 standards.

The standards are also available on our website: www.rcpsych.ac.uk/HTAS

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Section 1

Service provision and structure

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No.	Type	Standard
SECTION 1: Service Provision and Structure		
Policies and protocols		
1.1	1	There is a clear pathway for entry and exit from the service
1.2	1	The service has a Lone Worker Policy
1.3	1	The service is compliant with statutory guidance on the safeguarding of vulnerable adults and children
1.4	1	Confidentiality policies are upheld at all times when exchanging information
1.5	1	Protocols are reviewed at least every 3 years
Access		
2.1	1	The service has clearly documented acceptance criteria
2.2	2	The service has distributed their acceptance criteria to all referrers **Guidance:** *This includes help lines, GPs, police and Accident and Emergency departments, and patients and carers*
2.3	2	The acceptance criteria ensure that self-harm, including substance misuse, learning disability or personality disorder is not a barrier to appropriate service response
2.4	2	If necessary, the service team are able to support service users with drug or alcohol problems and mental illness
2.5	2	The service is able to accept direct referrals from service users who have a mental disorder of a nature and degree that would otherwise necessitate hospital admission, and/or their families/carers
2.6	1	The service is able to respond to requests for assessment from Accident & Emergency departments, or to signpost to appropriate assessment facilities
2.7	1	Referral protocols have been agreed for both outgoing and incoming referrals
Referral to other services		
3.1	2	The service can refer to child and family support services including child protection
3.2	2	The service has protocols governing links with out of hours telephone response services, where applicable
3.3	2	The service has access to independent advocates to provide information, advice and support to service users, including assistance with advance statements

3.4	2	The service supports service users to link with local collective advocacy organisations
3.5	1	The service is able to refer service users to self harm, alcohol and substance misuse services and for longer-term support with physical health issues if necessary
3.6	2	The service has community partnership arrangements to promote joint working between wider health and community organisations
3.7	1	The service can refer to Safeguarding Adults services
3.8	1	There are protocols in place to ensure service users are able to access physical health care services **Guidance:** *This includes GPs, district nurses, midwives, podiatry, dentistry and accident and emergency services*
3.9	2	Representatives from the service regularly attend Community Mental Health Team meetings, or routinely meet to exchange information
Equality and diversity		
4.1	2	Ethnicity monitoring forms are used to ensure that the level of ethnic diversity in the service is consistent with local demography
4.2	2	The service monitors the quality of experience and service received by people from equality target groups
4.3	1	Policies and procedures are assessed for equality impact at least every 3 years
4.4	1	The diversity of each service user is taken into account during assessment, treatment and support **Guidance**: *This includes age, disability, gender, ethnicity, religion and sexual orientation*
4.5	2	24 hour access to translation services is available
Initiating assessment		
5.1	1	The service has an agreed response time for accepting referrals, and the outcome is agreed with the referrer
5.2	2	The service is able to initiate assessment 24 hours a day, 7 days a week
5.3	1	The service has the capacity to allow for twice daily home visits to take place, as planned

5.4	2	Service users are treated as close to home and in the least restrictive environment as possible. **Guidance:** *This could include their own home, family accommodation or suitable respite facilities*
5.5	1	The service is able to conduct assessments in a variety of settings
Liaison with acute inpatient services		
6.1	2	There are systems in place to ensure continuity of care between the home treatment team, acute inpatient care and other services
6.2	1	The team is integrated with acute inpatient care **Guidance:** *This can be achieved by operational policies, ward rounds, routine screening for early discharge, joint acute care reviews, supported leave arrangements, sharing the same base location, shared consultant responsibility or shared acute care workers*
6.3	1	There is an acute care pathway which has been locally developed and agreed **Guidance:** *This includes interactions with primary care, Accident & Emergency, community teams and inpatient care, psychiatric intensive care units and crisis beds*
6.4	3	A representative of the service attends the local Acute Care Forum, or equivalent
6.5	1	The service gatekeeps all acute inpatient beds via face to face contact with service users
6.6	1	The service has a robust system of communication with acute inpatient services, including out of hours
6.7	1	There are specific link arrangements between acute inpatient wards and the home treatment team
6.8	2	If hospitalisation is required, service users are informed of the reasons why home treatment was not appropriate, the purpose, aims and outcome of the admission, and their expected length of stay

6.9	2	If hospitalisation is required, regular formal joint reviews of service users take place between acute inpatient and home treatment team staff, to ensure the service user is transferred to the least restrictive environment as soon as clinically possible
6.10	1	The service is involved in early discharge planning with acute inpatient services **Guidance**: i.e. *Discharge planning that would be not be available without the input of the home treatment team*
6.11	1	The service user and their family/carers are involved in discharge planning from acute inpatient services to the home treatment team
6.12	2	Primary care and other services involved in the service user's care are involved and kept informed of discharge plans from acute inpatient care
6.13	2	The service supports early discharge from acute inpatient services where appropriate, by offering intensive acute support in the service user's home setting within 24 hours of discharge
Audit		
7.1	2	There is a programme of audit
7.2	2	The service undertakes regular audit on its service provision, including feedback from service users and their families/carers.
7.3	2	The service has links with service user led organisations to provide input on practice and policy developments
7.4	3	Service users and their families/carers are involved in service planning and development
Feedback		
8.1	1	There are policies and procedures for managing complaints
8.2	3	Service user satisfaction feedback is gained after each care episode
8.3	2	There are procedures in place to record and feedback on referral outcomes to service users, their families/carers and referring organisations

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Section 2

Staff, appraisal, supervision and training

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No.	Type	Standard
Section 2: Staff, Appraisal, Supervision and Training		
The multidisciplinary team		
The team has dedicated sessional time from:		
9.1	1	A team lead
9.2	1	Community psychiatric nurse(s)
9.3	2	Social worker(s)
9.4	2	Occupational therapist(s)
9.5	2	Psychologist(s)
9.6	2	Support worker(s)
9.7	2	Pharmacist(s)
9.8	1	Consultant psychiatrist(s)
The team has access to:		
9.9	2	Service user support worker(s)
9.10	2	Approved mental health professional(s) (AMHPs)
9.11	2	The service has access to adequate administrative assistance to meet the needs of the service
Induction		
All staff have received a formal induction programme, which includes:		
10.1	1	Training in the principles of home treatment services
10.2	1	Training in the home treatment model and its implementation in the local context
10.3	1	Training on the roles and responsibilities of team members and staff in other services
10.4	1	Training in promoting recovery, safety and positive risk management
Appraisal and supervision		
11.1	1	There is a strategy and policy for staff annual appraisal, personal development planning and supervision
11.2	1	Staff receive regular formal clinical supervision, at least every 4 weeks

11.3	1	Staff receive regular professional supervision at least every 8 weeks
11.4	1	Practitioners are provided with debriefing sessions following major incidents **Guidance**: *This includes suicide, self-harm and aggression*
11.5	2	Staff receive regular team supervision
		Staff training
12.1	2	Staff have received training in delivering crisis resolution/home treatment interventions **Guidance:** *This may include psychosocial interventions, solution focussed brief therapy, family and social systems interventions and skills to respond appropriately to self-injurious or suicidal behaviour*
12.2	1	All staff have received training in carer awareness, family inclusive practice and social systems in the home treatment team **Guidance:** *Training should be delivered in collaboration with carers, and be updated at least every 2 years*
12.3	2	All staff have received training in basic counselling skills
12.4	1	All staff have received training on medication **Guidance:** *This includes storage, administration, legal issues, encouraging concordance and awareness of side effects*
12.5	2	All staff have received training in reflective practice and debriefing
12.6	1	All staff have received training on the relevant Mental Health Act and Mental Capacity Act
12.7	1	All staff have received training in personal safety issues **Guidance:** *This includes both personal and team safety, and procedures for visits and assessments*
12.8	2	There is clinical leadership training for registered mental health nurses (band 6 and above), psychiatrists and other members of the MDT.

12.9	2	All staff have taken part in team building, and training in colleague support and working within the team framework **Guidance:** *This should occur at least once a year*
12.10	1	All staff have received training on suicide prevention **Guidance:** *This should take place every 3 years*
12.11	1	All staff have received training in self harm
12.12	2	All staff have received training in alcohol and substance misuse
12.13	1	All staff have received training in diversity awareness
12.14	1	All training is monitored, reviewed and evaluated regularly
12.15	3	Service users, carers and staff are involved in devising and delivering training
12.16	2	Clinical staff receive training and support from staff with appropriate clinical skills to provide basic psychological and psychosocial interventions **Guidance**: *This includes, but is not limited to, conflict resolution/de-escalation, engagement and activity scheduling*
12.17	2	The team can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem-specific, low intensity psychological interventions in line with NICE guidance.
12.18	3	The team can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of problem-specific, high intensity psychological interventions in line with NICE guidance.

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Section 3

Assessment, care planning and transfer or discharge

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No.	Type	Standard
SECTION 3: Assessment, Care planning and Transfer or Discharge		
Consent and confidentiality		
13.1	1	The service user is asked what information, if any, they would like to be shared with their family/carers, and their consent (express or implied) is recorded
13.2	1	If the service user does not wish any information to be shared with their family/carers, staff regularly check whether they are still happy with this decision
13.3	1	The service offers information, advice and support to carers, whilst respecting the service user's wishes regarding confidentiality
Before the assessment		
14.1	1	The assessment includes a screening to establish if the service is appropriate for the service user
14.2	1	The service user's primary carer(s), or lack thereof, are identified and recorded
14.3	2	The service user, their family/carers and relevant others, e.g. their GP, are involved in the assessment
14.4	2	The service user is asked who they would like to be present during the assessment
14.5	2	Possible relationship tensions are taken into account when organising the assessment
14.6	2	The team ensure that the service user and their family/carers understand the purpose of the assessment
14.7	2	The service user is informed at the assessment of the expected length of time they will be involved with the service
The routine assessment		
The routine assessment gathered from multiple sources includes:		
15.1	1	An investigation into the nature of the crisis, and the presented problems
15.2	2	The identification of immediate social stressors and social networks
15.3	2	Psychiatric history including past records and family history
15.4	1	The identification of the presence of mental health problems, and their severity

15.5	1	The identification of the clinical signs and symptoms, if mental health problems are found
15.6	2	An investigation of comorbid physical health problems
15.7	2	An assessment of practical problems of daily living
15.8	1	A risk screening and assessment
15.9	2	The identification of the people affected by the crisis, and for whom it is a crisis
15.10	1	Identification of dependents and their needs, including childcare issues **Guidance:** *This should include the names and dates of birth of any young people*
15.11	2	A social assessment **Guidance**: *This should include education and employment*
15.12	2	A physical health assessment
15.13	1	A multidisciplinary assessment of the service user's needs
15.14	1	A multidisciplinary assessment of the service user's level of risk
15.15	2	Planning for supported transition to other services
Care planning		
16.1	1	The service works within the CPA Framework, or equivalent
16.2	1	The service is able to provide flexible and focussed care planning in collaboration with service users and their families/carers (where possible), covering acute care objectives
16.3	2	The care plan is reviewed in line with the service user's changing needs
16.4	2	Service users' existing advance directive or crisis plans are identified to establish their wishes in the event that risk is too great for them to be involved in care planning

Risk management		
17.1	1	The service formulates ongoing risk assessments and risk management planning, in collaboration with service users and their families/carers, which is reviewed at each contact
17.2	2	Risk assessments take into account risk for carers, and the impact on their role is considered
17.3	2	The family/carers are routinely offered the opportunity to meet separately from the service user to discuss risk management
Recovery		
18.1	3	A Wellness Recovery Action Plan (WRAP), or similar, is offered to all service users, which focuses on the service user's strengths, self-awareness, sustainable resources and support systems
Discharge planning		
19.1	1	Involvement of the service is time-limited, and service users are discharged when acute care is no longer necessary
19.2	2	The home treatment team begins discharge planning at the point of assessment, and this is communicated to relevant parties
19.3	2	The service is able to facilitate discharge and transfer of care to an appropriate service, dependent on clinical situation and local service provision **Guidance:** *This could include primary care, assertive outreach teams, early intervention teams, continuing care and other mental health services*
19.4	2	The service user and their family/carers are informed as early as possible of when their care is going to be transferred from the service
19.5	2	The service user and their family/carers are informed of where their care will be transferred to after being discharged from the service
19.6	2	Carers are informed when discharge is planned **Guidance:** *This includes what contact they can expect and how to plan themselves for the event*
19.7	2	Carers are involved in discharge planning

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Section 4

Interventions

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No.	Type	Standard
SECTION 4: Interventions		
Planning visits		
20.1	1	The team contacts the service user and their family/carers to agree on contact times, frequency and duration of contact
20.2	1	Service users and their families/carers are informed about unavoidable delays and told when to expect a response
20.3	2	Service users reach an agreement with the team about where they would like their assessment to take place
Contact with the team		
21.1	2	Each service user has a designated named worker, who is responsible for coordinating their care during the current episode
21.2	3	Service users and their families/carers are involved in selecting their designated named worker
21.3	1	Service users and their families/carers are given a direct contact number they can call for help, 24 hours a day
21.4	3	Where possible, the service user and their carer/family knows the workings hours of their named worker, so they are aware of when they can contact them
Information for service users		
22.1	2	Information can be made available as appropriate in a range of formats, including languages other than English, and in forms which people with cognitive, specific language, sight, learning and other disabilities can use
22.2	2	The service has an up to date directory of other local services, so service users are informed of how to access other appropriate services
22.3	2	Service users and their families/carers are routinely provided with information on their care plan, including comprehensive information about their medication
22.4	2	Before discharge, advance statements and/or crisis plans are explained to all service users, with the involvement of their care coordinator, and support is provided to complete these
22.5	2	The service advises service users on how to create an advance directive, and their care coordinator is involved in this

22.6	1	Information is provided for service users and their families/carers about how to make a complaint or compliment about any aspect of the service
Support for carers		
23.1	2	The service ensures that explanations are given to family/carers at all stages of the process
23.2	1	New carers are initially offered an appointment with a member of the team to discuss their concerns and family history
23.3	2	A letter is sent to new carers from the named worker, which includes names and contact details of key staff and other local sources of advice and support
23.4	2	If necessary, a dedicated worker is able to provide support to family/carers separate from the needs, and presence, of the service user
23.5	2	The team creates a plan around the whole family/group of carers, so that responsibilities of care are divided fairly
23.6	2	The service has a carer link, lead or champion
23.7	2	The service is able to signpost to educational or peer support groups for carers
23.8	1	Carers are offered an assessment of their caring, physical and mental health needs, and this is updated as a result of the acute episode **Guidance:** *This should be offered at the time of the service user's assessment*
23.9	2	Carers are offered a referral to the Carer Support Service
23.10	1	If the carer is 25 or under, they are asked if they would like to be referred to Young Carer services
23.11	2	The service ensures that children and other dependents are supported appropriately
23.12	2	A debriefing session is offered to all families/carers following a critical incident involving the service user **Guidance:** *This may include death, suicide, self-harm, compulsory treatment or violent or threatening behaviour*

23.13	2	Carers are supported to link with services who can assist in ongoing care
23.14	2	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
23.15	2	Information is routinely given to families/carers on how to access support services after discharge
Medicines management: Staff awareness		
24.1	2	The team has a nominated medicines management lead
24.2	1	Staff have received training in the clinical, practical and legal use of medicines **Guidance:** *e.g. with reference to the Nursing and Midwifery Council standards*
24.3	1	All clinical staff have received training in adherence to medication
24.4	1	There is a policy governing service user self-administration, including supervision and recording
24.5	2	There is a policy governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self harm
Medicines management: Medicines reconciliation		
25.1	2	All service users have a medicines chart, and if medicines are administered or supervised by the team, this is recorded on the chart
25.2	2	On admission to the service, a team member contacts the person's GP to obtain a copy of the person's medicines records **Guidance:** *This includes current medicines for mental and physical health, medicines history, recent laboratory results and any other issues which may impact on medicines*
25.3	1	When a service user is discharged from the home treatment team, a detailed account of the medicines prescribed is provided to their community mental health team and general practitioner

Medicines management: Prescription and administration		
26.1	2	The service has rapid access to medication, 24 hours a day
26.2	1	The service has 24 hour access to prescribing advice from a consultant psychiatrist or independent NMP
26.3	1	Medicines are only administered by doctors or qualified nurses
Medicines management: Support for carers		
27.1	2	The plan for managing medication concordance is agreed with family/carers, and reviewed regularly
27.2	3	The service provides training for family/carers to enable them to manage the medication of the person they care for **Guidance:** *This should include side effect profiles and information on dosage, frequency and storage*
27.3	3	Carers are able to contact an appropriately trained clinical pharmacist directly
Psychosocial interventions: psychological interventions		
28.1	2	The service has an adequate skill mix to provide a range of interventions
28.2	2	Gender sensitive services can be provided for service users and their families/carers if necessary
28.3	2	All service users are offered a psychological assessment delivered by a psychologist
28.4	2	The service is able to provide a range of therapies to service users and their family/carers based on need **Guidance:** *This includes problem solving, stress management, brief supportive counselling and relapse prevention*

Psychosocial interventions: Social interventions		
29.1	2	The service is able to offer interventions aimed at maintaining and improving service users' social networks, employment and education
29.2	2	The service supports service users to continue to attend community resources where this has been assessed for risk, such as faith communities and Alcoholics Anonymous
29.3	2	Information is offered to service users and their families/carers about transitional support services **Guidance**: *This includes mentoring, befriending, mediation and advocacy*
Crisis houses		
30.1	3	The service has access to a non-hospital residential service
30.2	3	Crisis house facilities are aware of the therapeutic aims of crisis resolution/home treatment
30.3	3	The service liaises with crisis houses **Guidance:** *This should include communication protocols, visiting frequency, reviews, etc.*
30.4	3	Clinical responsibility while a service user is in a crisis house is clearly defined
30.5	3	Responsibility for the storage and administration of medication while a service user is in a crisis house is clearly defined
30.6	3	There are arrangements for emergency medical care while a service user is in a crisis house

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Glossary, Bibliography and Feedback Form

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Glossary of terms and abbreviations

Term	Definition
Activity scheduling	A behavioural therapy for depression which encourages scheduling activities which improve mood
Acute Care Forum	A meeting of staff, service users and carers involved in care for people with severe mental health problems, both in and out of hospitals
Acute episode	Also referred to as a mental health 'crisis'. An episode of mental illness which is severe enough that the person experiencing it would usually have to be admitted to hospital
Acute inpatient care	Care provided on a residential psychiatric ward in a hospital
Advance statement/ directive	A document drawn up by a person when they are well, saying how they want to be cared for if they become unwell
AMHP	Approved Mental Health Professional. Staff trained in the use of the Mental Health Act
Assertive outreach team	A team which works with people with long-term mental health problems in the community
Carer link/lead/champion	A staff member within a team nominated to promote recognition of, and support for, carers
Carer Support Service	A local service which may provide information, individual support and peer support for carers
Clinical supervision	A professional relationship between a staff member and their supervisor. A clinical supervisor's key duties are: • monitoring employees' work with patients; • maintaining ethical and professional standards in clinical practice
Collective advocacy organisation	A group of people with similar experiences who meet to discuss and put forward shared views to service managers
Conflict resolution/de-escalation	Resolving a conflict situation and preventing it from becoming a major incident
CPA	Care Programme Approach - a way of coordinating care for people with mental health problems and/or a range of different needs
CPN	Community psychiatric nurse. A nurse specifically trained in mental health problems who sees people outside of hospital
Crisis bed	A bed in a non-hospital residential home (see Crisis house)
Crisis house	A non-hospital residential home for people experiencing an episode of severe mental ill health. Stays are short term and provide respite for carers.
Crisis plan	A document drawn up by a person when they are well, which includes their contact details, physical and mental health history, medications and therapy history, signs of relapse and instructions for care if they become unwell
Crisis resolution/home treatment team	Some teams call themselves 'crisis resolution', others call themselves 'home treatment', and some are both. These teams all treat people with severe mental health problems outside hospital - in their own homes or in suitable residential facilities
Dependents	Children or adults who depend on a person (i.e. the service user) for everyday care

District nurse	A senior nurse specialising in physical health who sees people outside of hospital
Early intervention team	A team which works with people who are at risk of, or currently experiencing, their first severe mental health episode
Family and social systems	Therapy that takes into account a person's social connections and how these may worsen their mental health, or improve it
Gatekeeping	Where a home treatment team offers an assessment to all people who might have to go to hospital due to severe mental health problems, to prevent people who could be treated outside hospital from having to be admitted
GP	General practitioner or 'family doctor'
HTAS	Home Treatment Accreditation Scheme. A programme which reviews crisis resolution/home treatment teams with the aim of helping them to improve their quality and awarding accreditation to good services
Independent advocate	A person who helps views of service users to be heard by service managers and protects vulnerable people
Lone Worker Policy	A policy to ensure the health, safety and welfare and reduce the risk to people who work alone i.e. when making visits in the community
MDT	Multidisciplinary team - a team made up of different kinds of health professionals
Mediation	Mediators act as a go-between for people with legal disputes. Some are trained in helping people with mental health problems
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interest or for the safety of themselves or others
NICE	National Institute for Health and Clinical Excellence. Publishes guidance for health services
NMP	Non-medical prescriber; health practitioners other than doctors who are qualified to prescribe medicines
OT	Occupational therapist. They aim to promote independence by providing help for people to complete activities in daily life
PICU	Psychiatric intensive care unit. A residential psychiatric ward which gives short term care to people during an episode of severe mental ill health
Primary care	Usually the first port of call for health problems. Includes general practitioners (GPs), dentists, community pharmacies and high street optometrists
Primary carer	The main person who looks after a person with mental health problems
Professional supervision	Usually a one-to-one meeting in which a staff member is supported by a more senior staff member to reflect on their work practice
Psychosocial interventions	Therapies that do not use drugs. Psychological or social techniques which are used to improve mental health
Signpost	To tell a person how they can access a related service
Solution focussed brief therapy	A therapy focussing on the present and future and what a person can achieve
Substance misuse	Can include the excessive or illegal use of alcohol or drugs
Team supervision	A group of staff meet to discuss and support each other regarding patients and other matters
WRAP	Wellness Recovery Action Plan - designed with the person who has mental health problems, stating everyday activities they can do to keep well, and triggers or warning signs that they are becoming unwell
Young Carers Service	A service which may provide information, individual support and peer support for carers under the age of 25

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HTAS Standards Feedback Form

We hope that you have found the HTAS standards useful and would very much appreciate your feedback. Your comments will be incorporated, with the approval of the HTAS members, into future editions of this publication.

1 Have you found these standards useful? *(delete as applicable)* Yes No

Comments:

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2 Do you have any suggestions for new sections or topic areas you would like to see included in future versions? (include references if necessary)

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3 Do you have any suggestions for new standards you would like to see included in future versions? (include references if necessary)

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4 Are there any documents not referenced here that would be useful to the standards?

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5 Do you have any general suggestions about the document that would make it more useful?

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6 What is your profession?

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