HTAS
HOME TREATMENT ACCREDITATION SCHEME

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Home Treatment Accreditation Scheme (HTAS)

Standards for Home Treatment Teams – First Edition

Editors: *Joanne Cresswell, Sophie Hodge and Emma Hailey*

February 2013

Pub. No. CCQI122

A manual of standards written primarily for:

Crisis resolution and home treatment teams

Also of interest to:
People who use crisis services
Carers of people who use crisis services
Commissioners
Policy makers
Researchers

First Edition February 2013

Correspondence:
Sophie Hodge
Home Treatment Accreditation Scheme
Royal College of Psychiatrists' Centre for Quality Improvement
Tel: 020 7977 4971
Fax: 020 7481 4831
Email: shodge@cru.rcpsych.ac.uk

A full copy of this document is available on our website at:
www.rcpsych.ac.uk/HTAS

The criteria associated with the standards have been classified as follows:

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

Type 2: criteria that an accredited service would be expected to meet;

Type 3: criteria that an excellent service should meet or criteria that are not the direct responsibility of the service.

NB: Underlined words are included in the glossary.

Foreword

We are very pleased to be publishing the First Edition of the Home Treatment Accreditation Scheme (HTAS) *Standards for Home Treatment Teams*.

HTAS is an accreditation service for Crisis Resolution Home Treatment teams, whose function is to provide home based acute care as an alternative to inpatient based acute care.

Home Treatment teams are unique services and the HTAS accreditation process attempts to address their needs. Key functions of such teams are gatekeeping acute inpatient admissions, offering a meaningful home-based alternative to acute inpatient admission and facilitating early discharge from acute inpatient wards.

Home Treatment teams are not all identical as they reflect local needs and interfaces, and the HTAS process embraces this. They should however have much in common, in terms of the difficulties they seek to address, the use of a recovery centred approach, encouraging an enabling and empowering ethos, using the full range of psycho-bio-social treatments including medication, psychological therapies, developing occupational and functional skills and working in close collaboration with service users and carers. Carers, in particular, potentially face an increased burden of care in home based acute care and good teams should pay particular consideration to carers and be mindful of the wider social environment.

These standards have been developed in consultation with a multidisciplinary group of people involved with the work of home treatment teams, as well as service users and carers. A pilot of this programme took place in 2012 with 17 teams around England and following this the standards were revised using feedback from the teams that trialled them, as well as the expert opinions of our standards development group.

This process was guided by staff from the Royal College of Psychiatrists Centre for Quality Improvement (CCQI). The names of the teams and individuals involved are listed overleaf and we are incredibly grateful for their input, enthusiasm and the support they have given to the programme.

Nigel Crompton, Chair of the HTAS Accreditation Committee
On behalf of the HTAS team
February 2013

Contents

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 team' 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**

Acknowledgements

The HTAS team would like to thank the following people for their input and support in compiling these standards:

Dr Alessandra De Acutis	East London NHS Foundation Trust
Francis Adzinku	Royal College of Nursing
Shamara Bailey	Oxleas NHS Foundation Trust
Leigh Bell	Service user representative
Dr Hermarette Van Den Bergh	Northumberland, Tyne and Wear NHS Foundation Trust
Val Berry	Humber NHS Foundation Trust
Polly Blaydes	Lincolnshire Partnership NHS Foundation Trust
Noorani Bocus	Oxleas NHS Foundation Trust
Dr David Branford	Derbyshire Healthcare NHS Foundation NHS Trust
Bromley Crisis Resolution Home Treatment Team	Oxleas NHS Foundation Trust
Central Cluster Acute Service Norwich	Norfolk & Suffolk NHS Foundation Trust
Cheltenham Crisis Resolution and Home Treatment Team	2gether NHS Foundation Trust
Dr Ruth Chester	British Psychological Society
City and Hackney Home Treatment Team	East London NHS Foundation Trust
Aisling Clifford	Camden & Islington NHS Foundation Trust
Crisis Assessment & Home Based Treatment Service Newcastle	Northumberland, Tyne and Wear NHS Foundation Trust
Crisis Resolution Home Treatment Team Northampton	Northamptonshire Healthcare NHS Trust
Nigel Crompton	Cheshire & Wirral Partnership NHS Foundation Trust
Croydon Home Treatment Team	South London and Maudsley NHS Foundation Trust
Lu Duhig	Carer representative
East Riding Crisis Resolution and Home Treatment Team	Humber NHS Foundation Trust
Chris Ellis	Avon and Wiltshire Mental Health Partnership NHS Trust
Gloucester Crisis Resolution and Home Treatment Team	2gether NHS Foundation Trust
Ian Griffiths	Camden & Islington NHS Foundation Trust
Dr John Hanna	British Psychological Society

Alan Howard	Development consultant, South West
Ian Hulatt	Royal College of Nursing
Hull Crisis Resolution and Home Treatment Team	Humber NHS Foundation Trust
Su Hurst	Oxleas NHS Foundation Trust
Islington Crisis Resolution & Home Treatment Team	Camden & Islington NHS Foundation Trust
Fiona Kilburn	Northumberland, Tyne and Wear NHS Foundation Trust
Natalie Larvin	Cheshire & Wirral Partnership NHS Foundation Trust
Dr Geoff Lawrence-Smith	Oxleas NHS Foundation Trust
Dr Chris Link	Cheshire & Wirral Partnership NHS Foundation Trust
Maidstone Crisis Resolution & Home Treatment Team	Kent & Medway NHS and Social Care Trust
Jane McLean	Lincolnshire Partnership NHS Foundation Trust
Lorette McQueen	East London NHS Foundation Trust
LT Merwood	Service user representative
Fiona Nolan	Camden & Islington NHS Foundation Trust
Carol Paton	Oxleas NHS Foundation Trust
John Robinson	Service user representative
Debbie Shepherd	Northumberland, Tyne and Wear NHS Foundation Trust
Simon Smith	Avon and Wiltshire Mental Health Partnership NHS Trust
Stamford & Grantham Home Treatment Team	Lincolnshire Partnership NHS Foundation Trust
Stroud and Cirencester Crisis Resolution and Home Treatment Team	2gether NHS Foundation Trust
Dr Mary-Jane Tacchi	Northumberland, Tyne and Wear NHS Foundation Trust
Dr Mark Taylor	NHS Lothian
Julie Taylor	Northumberland, Tyne and Wear NHS Foundation Trust
Tower Hamlets Home Treatment Team	East London NHS Foundation Trust
Wirral Home Treatment Team	Cheshire and Wirral Partnership Trust
Worcester, Malvern & Wychavon Home Treatment Team	Worcestershire Health and Care NHS Trust
Alan Worthington	Carer representative
Norman Young	Royal College of Nursing

Glossary of terms and abbreviations

NB: Words which are underlined in the main body of the standards are included in the glossary. Clicking on these words in the PDF version takes you to the glossary.

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
Administer medication	To prepare and check medications, ensuring that the right amount goes to the right person at the right time
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	A person who looks after a person with mental health problems. In this document usually refers to an informal carer, e.g. a relative or friend
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
CAT	Cognitive Analytic Therapy. A 'talking therapy' which aims to identify patterns of behaviour which lead to a target problem, and change these
CBT	Cognitive Behavioural Therapy. A 'talking therapy' focussing on challenging and changing negative thoughts and behaviour patterns
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
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	See 'acute episode'
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, usually with their Care Co-ordinator, which includes early warning signs and the steps to be taken to 'self manage'. The crisis plan will contain signs if relapse is not avoided; who will report them and the appropriate responses. It will record what actions have been helpful and unhelpful in the past
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
DBT	Dialectical Behaviour Therapy. A 'talking therapy' involving acceptance of the person's present feelings, changing behaviours such as self harm or attempts to take one's own life, and mindfulness or meditation exercises
Dedicated sessional time	An agreement that a member of staff works a certain number of hours per week for the team. This should be written into their job description. A session is half a working day
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	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 provides a face to face assessment to anyone at risk of admission to a psychiatric ward, to ensure they are treated in the least restrictive environment possible. Home treatment is provided as an alternative to hospital
GP	General practitioner or 'family doctor'
Graded exposure therapy	A 'talking therapy' addressing anxiety and phobia by gradually exposing a person to the threatening situation under relaxed conditions until the anxiety is gone
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
Managerial 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
MBT	Mentalisation-based Treatment. A 'talking therapy' aimed at improving a person's control over their behaviour and emotion

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
Mental health advocacy	A group of people with similar experiences who meet to discuss and put forward shared views to service managers
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
Peer support worker	A service user or carer employed by the team to support other service users and/or carers
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
Psychosocial interventions	Therapies that do not use drugs. Psychological or social techniques which are used to improve mental health
Schema-focussed therapy	A 'talking therapy' centred around a strong patient-therapist relationship, which aims to resolve unhealthy patterns of coping, usually developed in childhood
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
Support worker	An unqualified professional, e.g. healthcare assistant, occupational therapy support worker, psychology assistant, etc.
Team supervision	A group of staff meet to discuss and support each other regarding patients and other matters
WRAP	Wellness Recovery Action Plan. It is 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

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Section 1

Service provision and structure

HTAS
HOME TREATMENT ACCREDITATION SCHEME
CCQI

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 team
1.2	1	The team has a Lone Worker Policy
1.3	1	The team 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 team has clearly documented acceptance criteria
2.2	2	The team has distributed their acceptance criteria to all referrers **Guidance:** *This includes help lines, GPs, police and Accident and Emergency departments, and service users 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 team response
2.4	2	If necessary, the team is able to support service users with drug or alcohol problems and mental illness
2.5	2	The team 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 team 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 team can refer to child and family support services, including child protection
3.2	2	The team has protocols governing links with out of hours telephone response services, where applicable

3.3	2	The team has access to independent advocates to provide information, advice and support to service users, including assistance with advance statements
3.4	1	The team facilitates service users to access local mental health advocacy organisations
3.5	1	The team is able to refer service users to self-harm services if necessary
3.6	1	The team is able to refer service users to alcohol and substance misuse services if necessary
3.7	1	The team is able to refer service users to services for longer-term support with physical health issues if necessary
3.8	2	The team has community partnership arrangements to promote joint working between wider health and community organisations
3.9	1	The team can refer to Safeguarding Adults services
3.10	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*
Equality and diversity		
4.1	2	Ethnicity monitoring forms are used to ensure that the ethnic diversity of service users is consistent with local demography
4.2	2	The team 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, to ensure they are not discriminatory against any group
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 team has an agreed response time for accepting referrals, and the outcome is agreed with the referrer
5.2	2	The team is able to undertake assessment 24 hours a day, 7 days a week
5.3	1	The team has the capacity to allow for twice daily home visits to take place, 7 days a week
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 team is able to conduct assessments in a variety of settings
Liaison with other 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 team attends the local Acute Care Forum, or equivalent
6.5	1	The team gatekeeps all acute inpatient beds via face to face contact with service users

6.6	1	The team has a robust system of communication with acute inpatient services, including out of hours
6.7	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
6.8	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
6.9	1	The team 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*
6.10	1	The service user and their family/carers are involved in discharge planning from acute inpatient services to the home treatment team
6.11	2	The team 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
6.12	2	The home treatment team is able to transfer service users' care to a community mental health team as required
6.13	2	Local information systems are capable of producing accurate and reliable data about delayed transfers from the home treatment team to the community mental health team, and action is taken to address any identified problems
6.14	2	Service users, their families/carers and their care co-ordinator are involved in their transfer of care from the home treatment team to the community mental health team
6.15	2	Representatives from the team regularly attend community mental health team meetings, or routinely meet to exchange information

6.16	2	Health records can be easily accessed by other teams who may be involved with the service user's care during the episode **Guidance:** *This could include psychiatric liaison teams, Accident & Emergency, acute inpatient wards and primary care*
Audit		
7.1	2	There is a programme of audit
7.2	2	The team continuously audits service provision and outcomes, including feedback from service users and their families/carers
7.3	2	Service users and their families/carers are involved in service planning and development of the team at least once a year
7.4	2	The standard of care provided is consistent 24 hours a day, 7 days a week **Guidance:** *This should be monitored to ensure that standards are maintained if fewer staff work out of hours, or if the responsibility for home treatment passes to another team out of hours*
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 feed back on referral outcomes to service users, their families/carers and referring organisations

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Section 2

Staff, appraisal, supervision and training

HTAS
HOME TREATMENT ACCREDITATION SCHEME
CCQI

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	Registered mental health 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) **Guidance:** *An unqualified professional, e.g. healthcare assistant, OT support worker, psychology assistant, etc.*
9.7	2	Pharmacist(s)
9.8	1	Consultant psychiatrist(s)
9.9	3	Nurse prescriber(s)
The team has access to:		
9.10	2	Peer support worker(s) **Guidance:** *A service user or carer employed by the team to support other service users and/or carers*
9.11	2	Approved mental health professional(s) (AMHPs)
9.12	2	The team has access to adequate administrative assistance to meet their needs
Induction		
All staff receive a formal induction programme, by the end of which they understand the functions of the team, including:		
10.1	1	The principles of home treatment services
10.2	1	The home treatment model and its implementation in the local context
10.3	1	The roles and responsibilities of team members and staff in other services

10.4	1	Promoting recovery, safety and positive risk management
Appraisal and supervision		
11.1	1	All staff have an annual appraisal and personal development planning
11.2	1	Staff receive regular formal clinical supervision, at least every 8 weeks
11.3	1	Staff receive regular managerial supervision, at least every 8 weeks
11.4	1	Staff are offered debriefing sessions following major incidents **Guidance**: *This includes suicide, serious self-harm and aggression*
11.5	2	Staff receive regular team supervision
11.6	2	Psychiatrists in the team regularly attend team meetings
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	1	All staff have received training in basic counselling skills **Guidance:** *This could include, but is not limited to, CORE competency framework for CBT for depression and anxiety, Skills for Health competency framework for humanistic counselling, Gerard Egan's 'The Skilled Helper'*

12.4	2	All staff have received training on medication as required by their role **Guidance:** *This includes storage, administration, legal issues, encouraging concordance and awareness of side effects*
12.5	1	All practitioners who administer medications have been assessed as competent to do so. This is repeated on a yearly basis using a competency-based tool
12.6	2	All staff have received training in reflective practice and debriefing
12.7	1	All staff have received training on the relevant Mental Health Act and Mental Capacity Act
12.8	1	All staff have received training in personal safety issues **Guidance:** *This includes both personal and team safety, and procedures for visits and assessments*
12.9	2	There is clinical leadership training for registered mental health nurses (band 6 and above), psychiatrists and other members of the MDT
12.10	2	All staff have taken part in team building annually, training in colleague support and working within the team framework **Guidance:** *This should occur at least once a year*
12.11	1	All staff have received training on suicide prevention **Guidance:** *This should take place every 3 years*
12.12	1	All staff have received training in self harm
12.13	2	All staff have received training in alcohol and substance misuse
12.14	1	All staff have received training in diversity awareness
12.15	1	All training is monitored, reviewed and evaluated regularly
12.16	3	Service users, carers and staff are involved in devising and delivering training

12.17	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*
12.18	1	The team can demonstrate that qualified staff from nursing, OT, psychiatry and clinical psychology receive ongoing training and supervision to provide a repertoire of symptom- or problem-specific psychological interventions **Guidance:** *This includes anxiety management, relapse prevention, de-escalation intervention and graded exposure*
12.19	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 NICE-recommended, formulation-based specialist psychological interventions **Guidance:** *This includes:* ● *CBT for psychosis, bipolar disorder, and severe depression/ suicidality* ● *family interventions for psychosis and bipolar disorder* ● *DBT, MBT, CAT or schema-focussed therapy for personality disorder*

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Section 3

Assessment, care planning and transfer or discharge

HTAS
HOME TREATMENT ACCREDITATION SCHEME
CCQI

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 team 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 home treatment 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 that home treatment is a brief intervention, and of the average length of time they can expect to be involved with the team
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 review examination and investigations, which has been repeated at least annually
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
15.16	2	An assessment of basic psychological and social needs
Care planning		
16.1	1	The team works within the **CPA** Framework, or equivalent
16.2	1	The team 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 directives are identified to establish their wishes in the event that risk is too great for them to be involved in care planning

16.5	2	Service users' existing crisis plans are available in the event that they require home treatment
Risk management		
17.1	1	The team 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 team 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 team 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 team
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 team
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

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Section 4

Interventions

HTAS
HOME TREATMENT ACCREDITATION SCHEME
CCQI

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
20.4	3	If located in a rural area and no alternative can be arranged, the team has the ability to conduct visits remotely **Guidance:** *Visits could be conducted via, for example, Skype or FaceTime*
Contact with the team		
21.1	2	Each service user has a designated named worker **Guidance:** *The named worker is responsible for coordinating the service user's care during the current episode. They are not required to attend all visits to the service user*
21.2	3	Service users and their families/carers are able to change their designated named worker after discussion with the team
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	The service user and their family/carer are informed about when their named worker is normally at work 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 team 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, 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 team can signpost service users on to agencies who will advise on how to create an advance directive, if requested
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
22.7	2	Service users are made aware of how they can access their records if they wish to
Support for carers		
23.1	2	The team ensures that explanations are given to family/carers at all stages of the process
23.2	1	Every new carer is offered individual time with staff at least once during the episode of care to discuss concerns, family history and their own needs
23.3	2	Written information is given 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 team has a carer link, lead or champion
23.7	2	The team 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 team 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, serious 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 written policy governing service user self-administration, including supervision and recording

24.5	2	There is a written policy governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self harm
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 home treatment team, 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 team has rapid access to medication, 24 hours a day
26.2	1	The team 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 **Guidance:** *Medicines may be delivered by other staff provided they have been administered by doctors or qualified nurses*
26.4	2	Medical reviews are conducted at least once a year
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 team provides advice 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 team has an adequate skill mix to provide a range of interventions
28.2	2	Service users and their families/carers can be signposted to gender-specific services **Guidance:** *For example women- or men-only groups*
28.3	2	The team has the capacity to offer service users a psychological assessment and formulation delivered by a psychologist, based on clinical need
28.4	2	The team is able to provide a range of therapies to service users and their families/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 team is able to offer interventions aimed at maintaining and improving service users' social networks, employment and education
29.2	2	The team 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 team 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 team 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

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Bibliography

HTAS
HOME TREATMENT ACCREDITATION SCHEME
CCQI

Bibliography

Accreditation for Inpatient Mental Health Services (AIMS): Standards for Assessment/Triage Wards
Royal College of Psychiatrists (2010)

Carers and Confidentiality – Law and Good Practice
Machin (2004)

Crisis Resolution & Home Treatment
National Institute for Mental Health in England: NIMHE West Midlands

Crisis Resolution and Home Treatment: A practical guide
The Sainsbury Centre for Mental Health (2006)

Getting the Medicines Right 2: Medicines Management in Mental Health Crisis Resolution and Home Treatment Teams
National Mental Health Development Unit (2010)

Guidance Statement on Fidelity and Best Practice for Crisis Services
National Institute for Mental Health in England and Care Services Improvement Partnership (2007)

Memory Services National Accreditation Programme (MSNAP): Standards for Assessment and Diagnosis 2nd Edition
Royal College of Psychiatrists (2010)

Mental Health in Scotland. National Standards for Crisis Service: Crisis Services Practice Toolkit
Mental Health Foundation (2008)

Mental Health Policy Implementation Guidance: Crisis services
Department of Health (2001)

National Service Framework for Mental Health: Modern standards and Service Models
Department of Health (1999)

Standards for Acute Inpatient Wards for Working-Age Adults – 4th Edition (Re-Issue)
Royal College of Psychiatrists (2011)

Standards for Adult Inpatient Learning Disability Units – Assessment and Treatment Units – 2nd Edition
Royal College of Psychiatrists (2010)

The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care
National Mental Health Development Unit (2009)

HTAS
Royal College of Psychiatrists' Centre for Quality Improvement
4th Floor Standon House
21 Mansell Street
London E1 8AA

Tel: +44 (0)20 7977 4971
Fax: +44 (0)20 7481 4831
HTAS@cru.rcpsych.ac.uk

www.rcpsych.ac.uk/HTAS

Royal College of Psychiatrists Centre for Quality Improvement
4th Floor • Standon House • 21 Mansell Street • London • E1 8AA

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369)

www.rcpsych.ac.uk

COLLEGE CENTRE FOR QUALITY IMPROVEMENT