Isle of Man Government

Reiltys Ellan Vannin

MENTAL HEALTH SERVICE

Care Programme Approach (CPA) Policy

Incorporating Minimum Standards for Records and Record Keeping

Version 6.0

READER INFORMATION SUMMARY			
POLICY NAME	Care Programme Approach (CPA) - Incorporating Minimum Standards for Records and Record Keeping		
REASON FOR THE POLICY	This policy provides the framework for all patients receiving care and treatment from the Mental Health Service		
WHAT THE POLICY WILL ACHIEVE	This policy will enable staff to deliver personalised care within a structured framework and ethos of recovery, inclusive of assessment, care planning, co-ordination and review		
WHO NEEDS TO KNOW ABOUT IT	All Mental Health Service Staff (with the exception of Housekeepers)		
POLICY AUTHOR	Mental Health Service Policy Group		
CROSS REFERENCE DOCUMENTS	• Risk Management Policy • Out of Area Treatment (OATs) Policy • MHS Policy for Risk Assessment and Management of Self-Harm and the Prevention of Suicide • Service Operational Policies		
VERSION NUMBER	6.0		
APPROVING COMMITTEE	Mental Health Service Policy Group	**DATE**	27.08.2020
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VERSION CONTROL SHEET

Version No	Date	Section	Description of change
4.0	14 December 2018	All	Update and review of version 3.0 to ensure best practice and clarity.
5.0	February 2019	All	Annual review and update. Reverting to CPA Standard and Enhanced levels of care; incorporating new audit tool and patient feedback tool.
6.0	27 August 2020	13.3	Post discharge follow up appointment timeframe reduced from 5 days to 3 days.
		Appendix 1 – 2.1	Clarification that in addition to date, time and duration of appointment / interview with patient, location should also be noted
		Appendix 5	Question 27 added
		Appendix 6	Audit tool amended to include addition of information updated at 2.1 (as above)

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1. INTRODUCTION / BACKGROUND

This policy (referred to hereafter as CPA) provides the framework for **all** patients receiving care and treatment from the Isle of Man Mental Health Service (MHS), whether under Standard Care or Enhanced Care.

This policy will assist staff to deliver personalised care, within an ethos of recovery, in all approaches to assessment, care planning, coordination and review. All staff will be expected to be familiar and comply with the policy and those with direct responsibility for the coordination / delivery of patient care will be audited against the key standards identified throughout the policy.

The CPA was first introduced in England in 1991 to provide a framework for effective mental health care. The approach was subsequently revised following the introduction of the Department of Health (UK) document 'Refocussing the Care Programme Approach: Policy and Positive Practice Guidance (2008)'. This aimed to build on the foundations of the Mental Health National Service Frameworks (1999 and 2004) by:-

- Setting out an underpinning statement of values and principles that all secondary mental health services should aim for
- Highlighting positive practice around service users and carer involvement
- Provide a clearer definition of individuals and groups who need higher levels of engagement and coordination support
- Focussing on areas of assessment and care planning that should be strengthened
- Presenting an overview of systems that can support multi-agency delivery of care to meet the range of the individual's needs
- Strengthen workforce capability by describing the core competencies to be a care coordinator
- Commissioning training for CPA, risk and safety management

A number of standards contained within this policy have been adopted from UK standards for CPA.

2. PURPOSE OF POLICY

This policy is concerned with providing a clear, consistent framework for the provision of specialist mental health services and the standards against which delivery will be measured.

3. SCOPE

All patients in receipt of care and treatment from the MHS.

4. STATEMENT OF VALUES AND PRINCIPLES

CPA is called an "approach" rather than just a system, because the way the elements are carried out is as important as the actual task themselves (Department of Health, 2008).

The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful, building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient second.

Care assessment and planning views the person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including family, parenting, relationships, housing, employment, leisure, education, creativity, spirituality, self-management and self-nurture; with the aim of optimising mental and physical health and wellbeing.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

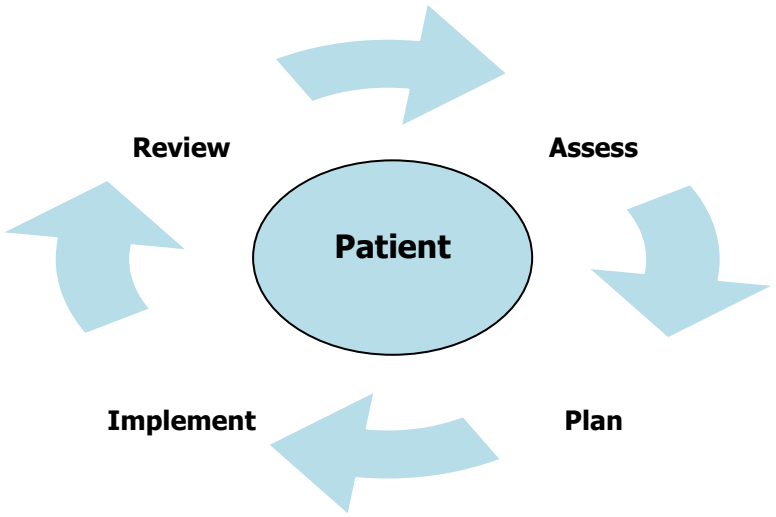
Carers form a vital part of the support required to aid a person's recovery. Carer's needs should be recognised and supported, where appropriate.

Services should be organised and delivered in ways that promote and coordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification and organisation of diverse opinion to deliver valued, appropriate, equitable and coordinated care. The quality of the relationship between the patient and the care coordinator is one of the most important determinants of success.

Care planning in many respects is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

As a minimum and regardless of the level of care, all patients allocated to the Mental Health Service (MHS) will have an individual care plan and risk management plan, which they have been involved in developing, and which is based on an assessment of their health and social care needs. The patient and those involved in their care should receive a copy of that care plan (with consent from the patient, where possible).

The process of assessment and review should be cyclical, demonstrated as follows:-



5. ROLES AND RESPONSIBILITIES

Head of Mental Health Service: responsible for ratifying Mental Health Service policies on behalf of the Community Care Directorate Senior Leadership Team (SLT) and for ensuring policy compliance.

Head of Care Quality & Safety: responsible for the management and oversight of a range of governance related activities, reporting risks and providing assurance to the Community Care Directorate Senior Leadership Team.

Care Quality & Safety Committee (MHS) / MHS Policy Group: responsible for approving the policy, ensuring the policy is evidence-based, reviewed in accordance with identified time frames and audited, with results and action plans monitored by the Committee.

Operational Managers: responsible for the implementation of the policy within their areas of responsibility, ensuring compliance.

Care Quality & Safety Team: responsible for monitoring compliance and supporting service delivery via a programme of audit.

All MHS staff (with the exception of Housekeepers): responsible for ensuring compliance with this policy.

6. MINIMUM STANDARDS FOR RECORDS AND RECORD KEEPING

The minimum standards outlined in Appendix 1 apply to all staff and all patient records within the Mental Health Service.

7. ELIGIBILITY FOR ALLOCATION OF CARE LEVELS

The MHS will deliver care according to two levels of need:-

- **Standard Care**
- **Enhanced Care**

The difference between Standard Care and Enhanced Care is based on the nature and degree of assessed need when considered in terms of complexity, associated risk and extent of service intervention required for the patient **specifically in relation to their mental health**. The flowchart at Appendix 2 summarises the key considerations in allocating the appropriate level.

A decision regarding eligibility for Standard Care or Enhanced Care should be made as soon after assessment as possible, when sufficient information is available to do so. However, there are occasions when the level of care will be automatically determined; for example, all inpatients will be subject to Enhanced Care and patients receiving support at Step 2 will be Standard Care. Where care level requirements are unclear, clarity should be sought from the multidisciplinary team, line manager or clinical supervisor.

Where assessment is ongoing or incomplete (and it is felt that there is not yet enough information available to make a reliable decision), but the individual has been accepted for a service, they should be registered on Standard Care until a definitive decision is reached.

7.1 Criteria for Standard Care

Patients appropriate for Standard Care are likely to have some of the following characteristics:-

- Support or intervention of one agency or discipline, or only low key support from more than one agency or discipline

- Ability to self-manage their mental health problems
- An active informal support network
- Pose little danger to self and / or others
- Little or manageable risk of self-injury
- Likely to maintain appropriate contact with services

7.2 Criteria for Enhanced Care

People with complex mental health and social care needs will require a higher degree of monitoring and coordination of care. Patients appropriate for Enhanced Care are likely to have some of the following characteristics:-

- At risk of losing contact with services; disengage as part of a relapse signature or suspected mental health deterioration
- Pose a significant risk to themselves and / or others or have a history of serious self-harm or violence
- Multiple care needs e.g. housing, employment, finances
- Require contact with, and coordination between, a number of agencies or professionals but may be willing to co-operate with only one
- Lack an informal support network
- Have addiction problems in addition to a primary diagnosis of mental illness
- Children / Young People who are not in education and / or training due to a significant mental illness / mental health problem
- Children who are 'Looked After' in addition to a primary diagnosis of a mental illness / disorder, or where there are significant safeguarding concerns

Enhanced Care is also strongly indicated for those:

- With an established psychosis
- With a long-standing, complex presentation
- With a history of treatment resistance or frequent presentations / referrals
- Exhibiting co-morbidity (e.g. Severe Depression and Personality Disorder; Complex physical health and mental health needs; Learning disability and mental illness)
- Patients subject to Aftercare under Section 115 of the Mental Health Act

7.3 Transfer between Standard Care and Enhanced Care

The need and degree of support required by patients can change during the course of contact with mental health services. It is recognised therefore that the level of care can also change accordingly between Standard and Enhanced and vice versa.

The level and extent of care requirements should be reviewed and re-assessed on a regular basis to ensure that support and treatment is being appropriately provided. Transfer between levels of care will usually occur within the context of a review of care, with the awareness and agreement of all those involved, including the patient and carer (if and where appropriate).

Any change in the patient's level of care should be explained to the patient, carer (where appropriate) and other care agencies, and clearly recorded in the patient's record.

8. ROLE OF THE LEAD PROFESSIONAL AND CARE COORDINATOR

8.1 Lead Professional

Patients who are subject to Standard Care will be allocated a **Lead (MHS) Professional**, who is responsible for:-

- Conducting an assessment of needs and risk
- Agreeing with the patient a plan of care
- Ensuring that the care plan is reviewed, updated and shared
- Reviewing the patient's progress on a regular basis, and at least every 6 months; with the exception of the following:
    - Patients reviewed at 12 month intervals by the Memory Service identified as experiencing Mild Cognitive Impairment (MCI)
    - Patients who are considered stable, that are only allocated to doctors, and whose GP requires an annual review of their medication or need to be reviewed as part of a shared care agreement; the care for these patients must be reviewed at least every 12 months
- Identifying and liaising with carers (where appropriate), considering their support needs (if / where appropriate)
- Maintaining accurate records (in accordance with Minimum Standards)

Note: Whilst all patients open to the MHS will be subject to assessment, care planning, risk management and review, this does not require completion of the CPA Care Planning documentation within the RiO system for those on Standard Care. The information can be contained in standardised letter format.

8.2 Care Coordinator

Patients who are subject to Enhanced Care will be allocated a **Care Coordinator**. The role of the Care Coordinator must be undertaken by the qualified professional who is best placed to oversee care management and resource allocation.

The Care Coordinator can be of any discipline, with allocation dependent on several factors, including professional background, capability and existing caseload.

The Care Coordinator will be responsible for the following:

- Comprehensive Needs Assessment
- Risk Assessment and Risk Management Plan
- Design and implementation of a CPA Care Plan
- Multi-Disciplinary review of the care plan, at least every six months
- Consult with, and consider the needs of, carers and where necessary / appropriate, respond to those needs
- Transfer of care or discharge
- Maintaining accurate records (in accordance with Minimum Standards)

9. CARER INVOLVEMENT

The term 'carer' is generally used for people who provide regular and substantial care and support to others and can include relatives, friends and neighbours. To be considered a carer

you do not have to live with the person (patient) and the extent of care provided can fluctuate over time.

The MHS recognises the importance of the involvement of carers in the assessment, planning and implementation of care plans. Carers should be perceived and treated as genuine partners in care, with valuable expertise, experience, understanding and knowledge. Involving and including carers in an individual's programme of care is often a major contributory factor in promoting recovery. The role of carers is likely to be significant for patients in receipt of Enhanced Care, whereas with Standard Care involvement of carers may be less significant or in some cases not appropriate.

Issues of confidentiality and information sharing between mental health professionals and carers can be complex and challenging, but can often prove crucial to the wellbeing of patients and carers. If carers are excluded from important discussions and decisions involving the patient, this can have serious consequences and may increase feelings of isolation, anxiety and concern. The following may be helpful to guide decision making concerning the involvement of carers:

"Issues around confidentiality should not be used as a reason for not listening to carers, nor for not discussing fully with service users the need for carers to receive information so that they can continue to support them. Carers should be given sufficient information, in a way they can readily understand, to help them provide care effectively."
(Department of Health, 2002)

MHS professionals should encourage patients to understand the benefits of sharing appropriate information with their relatives / carers. The issue of confidentiality should be discussed with the patient at an early stage, when they are not acutely ill, ensuring that outcomes and decisions are clearly documented in the patient's record to enable continuity of care.

However, even when the patient continues to withhold consent, carers can be given sufficient knowledge to enable them to provide effective care. This may include general information on a wide range of issues relating to mental illness, medication and treatment issues, legislation, benefits, rights for both patients and carers and the range of local services available.

Carers can also be given the opportunity to discuss any difficulties they are experiencing in their caring role. The provision of general information about mental illness, emotional and practical support for carers does not breach confidentiality; however it must be recognised there may be occasions when the level and nature of risk is such that disclosure is required in order to prevent harm. Such a duty is covered by Principle 7 of the Caldicott Principles:

The duty to share information can be as important as the duty to protect patient confidentiality

Work has been undertaken in the UK to look at effective ways for professionals to involve carers in information sharing and Appendix 3 summaries key points / considerations.

POLICY STANDARD

- All patients of the Mental Health Service will be screened at assessment and review to identify carers who provide regular and substantive care. This information will be recorded in the CPA Needs Assessment, screening tool or letter to the GP in the case of Standard Care (where carer involvement is considered relevant / appropriate).

10. ASSESSMENT

10.1 Needs Assessment

A needs assessment must be completed by a Health and / or Social Care Professional for all patients who, following referral to the MHS, meet the criteria for allocation.

Assessment must ensure that patient strengths and the potential for recovery are considered / identified. In all cases, assessment will be initiated at the first face-to-face contact with the Mental Health Service; however information obtained via the initial referral and subsequent screening e.g. telephone contact with the referrer, will contribute to the assessment process.

One member of staff will usually have responsibility for undertaking the assessment; however where there are other agencies involved and where it is appropriate and / or practical, joint assessment is desirable. The assessment will aim to provide information about all the needs of the patient from the perspectives of the patient, carer / family and assessor (clearly differentiating between these if and where they differ).

Needs assessment implies a focus on the person's needs, rather than the services and resources available. It is a continuous process, subject to review, based on the identification of strengths and vulnerabilities.

Whilst the nature and extent of assessment must be proportionate to the presenting need / problem and the level of care (Standard or Enhanced), the assessment should incorporate a proportionate history and for Enhanced Care consideration of the following:-

- Mental Health (comprehensive psychiatric history and mental state examination)
- Physical Health
- Risk
- Safeguarding
- Substance Misuse
- Behavioural Addictions
- Social Functioning
- Personal / Family Circumstances
- Child Care / Protection issues
- Employment, Vocational and Leisure needs
- Finances / Welfare Benefits
- Accommodation
- Medication
- Religious and Spiritual needs
- Communication, Disability and Cultural needs
- Views of families and carers should be included (where appropriate)

For Enhanced Care the assessment will be recorded using the CPA Needs Assessment documentation, or a standardised letter to the GP in the case of Standard Care.

Where the standardised letter format is used, the evidence of needs assessment must be clearly documented, as well as the care plan. This can be printed as an 'editable letter' within RiO in the same way as the RiO / CPA Printable Care Plan and Review document.

The depth and detail of the information recorded should always be proportionate and adequately reflect the nature and complexity of the individual presentation.

The assessment will usually involve at least one meeting with the patient (though it may require a number of contacts for those presenting with more complex needs) and should aim to gather sufficient information to make a judgement about:-

- Eligibility for service
- Type of intervention / support required
- Level of service (Standard or Enhanced)

POLICY STANDARD

- All patients will have a needs assessment

10.2 Risk Assessment and Management

All patients will have an individual assessment of risk, resulting in a risk management plan. For staff accredited as having completed training in the DICES Risk Assessment & Management System, this should be utilised for all patients, completing the BRIEF-DICE as a minimum. Where staff are awaiting DICES training, the CPA Risk Assessment and Management Plan on RiO and / or "Letter to GP as Mental Health Care Plan" will provide documented evidence of risk assessment.

It is important that practitioners give careful consideration to managing the risk factors identified during assessment. This will be demonstrated by completing a Risk Management Plan, wherever possible with the patient. The Risk Management Plan will be shared with the patient, Multi Disciplinary Team and other relevant individuals (carer, GP etc.) where patient consent allows.

Risk management strategies could include the need to:-

- be aware through observation and ongoing communication of changes in the behaviour of the patient;
- spend time with the patient in order to be aware of changes in their mental state and behaviour;
- be alert and vigilant to potential hazards;
- be aware of the patient's history;
- be aware of the patient's current feelings on their own level of risk;
- consider who / what might be harmed and how;
- evaluate whether current arrangements adequately address the risk and decide whether further measures need to be taken;
- record in writing exactly what risks are thought to be present, and what action is being taken in mitigation;
- identify and record the level of risk that is being accepted for an individual, bearing in mind the practical constraints, resource availability and the rights of the individual to be treated in the least restrictive manner compatible with the assessed risk;
- ensure that a regular review system is established so that levels of risk can be revised in the light of more recent information;
- exchange information so that all relevant parties have knowledge of risk factors and manage risks effectively at the team level;
- ensure the wellbeing and safety of children and vulnerable adults is of paramount importance.

For further information, please refer to the Risk Management Policy and the DICES Risk Assessment and Management System.

POLICY STANDARD:

- All patients will have an individualised risk assessment and risk management plan

11. CARE PLANNING

Every patient will have a written care plan, which they and their carer (where appropriate) have been involved in developing. This will be based on an assessment of need, risk and strengths which identifies specific interventions, how and when these will be carried out and by whom.

The care plan will identify the Care Coordinator or Lead (MHS) Professional, all people involved in the care of the patient and include the actions for which the patient will take responsibility.

Alternative views in the record / care plan should be clearly documented and all those involved in the care of the patient should be offered a copy of the care plan. If the patient declines a copy of the care plan, or where the Service has made a decision not to provide a copy to the patient, a rationale must be documented in RiO.

For patients subject to Section 115 of the Mental Health Act 1998, this should be documented as part of the Care Plan.

POLICY STANDARDS:

- Every patient will have a Care Plan based on assessed need and risk
- The Care Plan will identify the Care Coordinator or Lead (MHS) Professional
- The Care Plan will demonstrate patient involvement
- The Care Plan will demonstrate carer involvement (where appropriate)
- A copy of the Care Plan will be offered to the patient
- A copy of the Care Plan will be offered to the carer (where appropriate)
- When a copy of the Care Plan hasn't been provided, a rationale is documented in RiO

12. REVIEW

Review is a structured and flexible process as well as a planned periodic event. Care plans will be formally reviewed at least every 6 months and this will involve the patient and where appropriate, the carer. For patients who have disengaged from the service and are considered suitable for discharge, this should be documented as a formal review.

The only exceptions to the 6 month review timeframe are:

- Patients of the Memory Service identified as experiencing Mild Cognitive Impairment (MCI) and who are therefore open to the Older Persons Mental Health Service – the care for these patients must be reviewed at least every 12 months

- Community patients who are considered stable, that are only allocated to doctors, and whose GP requires an annual review of their medication or need to be reviewed as part of a shared care agreement; the care for these patients must be reviewed at least every 12 months

For patients subject to Enhanced Care, formal reviews should seek feedback from the patient (see Appendix 4) in order to ensure the approach is patient centered and to ascertain compliance with the standards contained within this policy.

POLICY STANDARDS:

- All patients will be subject to review at least every 6 months
- All patients on Standard Care allocated to the Memory Service with MCI will be reviewed at least every 12 months
- All patients allocated on Standard Care to a community Doctor whose GP requires an annual review of specific medication will be reviewed as least every 12 months
- Patients will be provided with the opportunity to provide feedback at each formal CPA Review

13. TRANSITION POINTS IN CARE

13.1 General Transition Points

Transitions in care have the potential to affect risk and compromise continuity and are therefore vulnerable points where things can go wrong, sometimes with negative consequences for the patient and their carer(s). Transitions sometimes occur with very little warning to those involved and require a timely response to ensure that the required information is communicated to those who need to know.

On other occasions transitions are carefully planned over time, for example, discharge from a secure hospital will usually involve detailed planning and preparation of services long before the actual date of discharge.

The care planning process should provide the supporting framework and evidence for decisions relating to any kind of transition and it is important that the 'receiving' team feel they have sufficient background information to aid their own assessment and care planning process.

Examples of transition points:-

- Admission to, or discharge from, hospital or similar residential establishment
- Move to a different geographical location
- Containment in, or release from, the criminal justice system
- As a result of the Mental Health Act, including Supervised Discharge
- Transfer from Child and Adolescent Mental Health Services (CAMHS) to Adult Services
- Transfer from Adult Services to Older People Services
- Transfer of Care Coordinator within the same team
- Referral to / from independent sector

13.2 Interface between Inpatient and Community Services

Admission to and discharge from inpatient services is a common and vulnerable transition point, where effective communication and liaison between community and inpatient staff is essential.

An admission to a Mental Health Service inpatient facility for patients already known to the Service must not be seen as the end of one episode of care and the beginning of another, but viewed as a change in the location of the delivery of care.

Whilst the inpatient service will allocate a Named Nurse for the duration of the admission, Care Coordinator responsibility remains with the allocated community professional during the inpatient episode and this includes maintaining contact with the patient and carer, and others involved in the care, including non-statutory organisations. Also, in conjunction with inpatient staff, the Care Coordinator retains responsibility for reassessing the patient's needs and risk

prior to discharge from the inpatient unit.

Patients admitted to inpatient services will **always** be subject to Enhanced Care, even if previously on Standard Care and this will be reflected in the 'CPA management' form in the patient's RiO record.

Good communication and robust working arrangements between hospital and community services is fundamental to the effective operation of the CPA. To ensure continuity of care planning arrangements, inpatient services will utilise the RiO CPA Care Plan and, subject to completion of training, the DICES Risk Management Plan.

Given patients admitted to inpatient facilities are amongst the most vulnerable in the Mental Health Service, it is imperative this group are prioritised for community support at an early stage of their inpatient admission. Referral for community follow up will be processed by inpatient staff as soon as reasonably practicable and allocation to a community professional will occur within 10 working days of referral. This will allow a Care Coordinator opportunity to build a relationship with the patient in preparation for the continuing support following discharge.

POLICY STANDARDS:

- All patients admitted will be placed on Enhanced Care
- Allocation to a community professional will occur within 10 working days of referral

13.3 Discharge from Inpatient Services

Discharge planning should begin at the point of admission. In planning discharge, full consideration should be given to how best to facilitate a supportive move back into the community. This will involve close liaison with carers and other providers of services involved in the care plan, ensuring all parties are kept fully aware of discharge planning arrangements and invitations to the Ward Round / Discharge Planning Meeting, which will be considered a full CPA Review meeting.

All patients will remain subject to Enhanced Care until their follow-up discharge appointment, when a decision can be made as to the continuing level of support (i.e. Standard Care or Enhanced Care). Evidence emphasises that follow-up within 2 to 3 days of discharge can reduce risk of patient suicide (National Confidential Inquiry into Suicide and Safety in Mental Health 2019); however the timing of follow-up will be determined by individual risk assessment, with all appointments taking place within a **maximum of 3 days** post discharge.

Patients discharged from an inpatient facility should have a clear, up to date CPA Care Plan and Risk Management Plan. Inpatient entries to the care plan should be closed where they are no longer relevant on discharge. A copy of the plans should be offered to the patient and their carer (where appropriate) on the day of discharge. At the time of discharge all patients, including those returning from an out of area placement, should have a follow-up appointment arranged with their Care Coordinator / nominated professional within 3 days.

A **Discharge Summary** should be sent to the GP and other relevant parties within **24 hours** of discharge, incorporating admission / discharge dates, diagnosis and prescribed medication. A more detailed summary will be sent to the GP and other relevant parties within **5 working days** of discharge.

If for any reason the patient has not been able to receive a copy of the Care Plan on discharge and they have opted to receive same, a copy should be sent to their home or postal address within 48 hours of discharge. Where possible and appropriate, this should also be shared with their carer.

In circumstances where it has not been possible for a community Care Coordinator to be allocated, the Crisis Response Home Treatment Team will have interim responsibility for the CPA Care Plan and Risk Management Plan until transfer of care has been arranged.

In instances where a patient is being discharged from inpatient services and the community Care Coordinator is on leave, the community team will arrange for an alternative professional to cover until the allocated Care Coordinator is able to resume the role.

POLICY STANDARDS:

- The Discharge Planning Meeting / Ward Round is considered a CPA review and will be documented as such by the community Care Coordinator / Named Nurse
- Upon discharge all patients will have an up to date Care Plan and Risk Management Plan
- All patients will be offered / receive a copy of the care plan on discharge (or posted to them within 48 hours if this has not been possible)
- All carers (where appropriate) will be offered / receive a copy of the care plan on discharge
- A Discharge Summary will be sent to the GP within 24 hours of discharge
- A detailed Discharge Summary will be sent to the GP and other relevant parties within 5 working days of discharge
- All patients will be offered a follow-up appointment within 3 days of discharge

14. DISCHARGE FROM STANDARD CARE OR ENHANCED CARE

A formal review will be undertaken, wherever possible, before a patient can be discharged from either Standard Care or Enhanced Care. However, it is recognised there may be occasions when this is not possible; for example, when the patient leaves the Island at short notice or refuses to engage (and has capacity to make decisions / consent). For patients on Enhanced Care it may be advantageous to transfer to Standard Care for a brief period of monitoring prior to complete discharge.

15. TRANSFER FOR OUT OF AREA TREATMENT

Please refer to the relevant Directorate Policy.

16. LOSS OF CONTACT OR DISENGAGMENT FROM SERVICES

Please refer to the individual statements within service operational policies concerning 'Patients who Do Not Attend Appointments (DNA)'.

17. MONITORING AND AUDIT

Compliance with CPA standards for Standard Care and Enhanced Care will be audited at two levels:

#	Type	Responsible	Volume and Frequency
1	Local	Service Manager	Locally determined for the purpose of caseload / performance management

2	External CPA Audit	Care Quality & Safety Team	A schedule of audit will be determined, proportionate to the caseload size of the MHS

Level 1 audit outcomes will be managed locally by service managers and integrated into management supervision; ensuring key outcomes are reported via service reports to the Care Quality & Safety Committee.

Level 2 audit outcomes will be reported by the Care Quality & Safety Team to the Service Manager and the Care Quality & Safety Committee (MHS).

17.1 Key Standards for Standard Care and Enhanced Care

- All patients of the Mental Health Service will be screened at assessment and review to identify carers who provide regular and substantive care. This information will be recorded in the CPA Needs Assessment, or letter to the GP in the case of Standard Care (where appropriate)
- All patients will have a needs assessment
- All patients will have an individualised risk assessment and risk management plan
- Every patient will have a Care Plan based on assessed need
- The Care Plan will identify the Care Coordinator or Lead (MHS) Professional
- The Care Plan will demonstrate patient involvement
- The Care Plan will demonstrate carer involvement (where appropriate)
- A copy of the Care Plan will be provided to the patient
- A copy of the Care Plan will be provided to the carer (where appropriate)
- When a copy of the Care Plan hasn't been provided, a rationale is documented in RiO
- All patients will be subject to review at least every 6 months
- All patients on Standard Care allocated to the Memory Service with MCI will be reviewed at least every 12 months
- All patients allocated on Standard Care to a community service doctor whose GP requires an annual review of their medication will be reviewed as least every 12 months
- On discharge from hospital, all patients will have a Care Plan and Risk Management Plan incorporating a contingency plan
- All patients will be offered / receive a copy of the care plan on discharge from hospital
- All carers (where appropriate) will be offered / receive a copy of the care plan on discharge from hospital
- A Discharge Summary will be sent to the GP within 24 hours of discharge
- The Care plan will be sent to the GP and other relevant parties within 5 working days of discharge
- A CPA Review will occur at the point of discharge from the inpatient unit
- All patients will be offered a follow-up appointment within 3 days of discharge

17.2 Record Keeping Standards

Compliance with record keeping standards will be audited at two levels:-

#	Level	Responsible	Volume and Frequency
1	Local	Service Manager	Locally determined for the purpose of caseload / performance management
2	External	Care Quality & Safety Team	Compliance with record keeping standards will be picked up as part of the CPA audit and service wide compliance with the Minimum Data Set, reported monthly

Level 1 audit outcomes will be managed locally by service managers and integrated into management supervision; ensuring key outcomes are reported via service reports to the Care Quality & Safety Committee (MHS).

Level 2 audit outcomes will be reported by the Care Quality & Safety Team to the Service Manager and the Care Quality & Safety Committee (MHS).

18. TRAINING NEEDS

Policy Name	**Care Planning Standards Policy**
What Training Needs are identified?	Policy awareness and understanding
How many staff will require this?	All clinical and administration staff
Who will deliver this?	Care Quality and Safety Team
How will this be delivered?	Induction (new staff) Updates via policy circulation and eLearn Vannin
When will this be delivered?	On Induction
Is there a cost?	Time and Motion
Frequency of updates?	As policy is updated
Mandatory? (for whom)	For all clinical and administrative staff

19. REFERENCES

Department of Health (2002). *Developing services for carers and families of people with mental illness.* Page 16.

Department of Health (2008). *Refocussing the Care Programme Approach.* Pages 7 and 11.

Isle of Man Government (1998). *Mental Health Act.* Page 99.

Rethink & Health Services Research Department at the Institute of Psychiatry (2005). *Report to the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). Positive and Inclusive? Effective ways for professionals to involve carers in information sharing. Page 170.*

Isle of Man Government (2015). *Strategic Plan for Mental Health and Wellbeing.* Page 16.

The University of Manchester (2019). *National Confidential Inquiry into Suicide and Safety in Mental Health.* Page 6.

Appendix 1

Minimum Standards for Records and Record Keeping

1. INTRODUCTION

The standards identified within this policy are the minimum standards expected of all practitioners employed by the Department of Health and Social Care's Mental Health Service (MHS).

Record keeping is integral to good professional practice and the MHS depends on the records it holds to operate effectively, efficiently and safely and to be able to account for its actions. The Service and all employees have a statutory (Data Protection Act and General Data Protection Regulation 2018) and professional obligation (with professional regulatory bodies) to maintain accurate records of its activities and to make arrangements for their safe keeping and secure disposal.

Clinical information is considered the 'lifeblood' of health and social care organisations and is essential for the delivery of high quality, evidence-based health care on a day-to-day basis. Clinical records are a valuable resource because of the information they contain. Such information is only usable if it is correctly recorded in the first place, regularly updated and is easily accessible when needed.

The MHS is committed to a systematic and planned approach to the management of patient records, controlling both the quality and quantity of information generated, maintaining and storing records so that they serve the purpose for which they are generated and that all records are effectively controlled from creation to destruction.

Failure to record information accurately in care records can have serious consequences for patients, their relatives, individual employees and the organisation. Such failures may result in reduced quality of care, impaired safety and in some cases litigation.

In addition to the minimum standards required for record keeping, the MHS acknowledges the importance of involving patients in their care and taking the opportunity to share information wherever possible. An open and honest approach can have numerous benefits, including enhanced patient experience / engagement and limitations on the submission of Subject Access Requests (SARS) and formal complaints.

This policy describes the basic record-keeping standards that all staff are required to adhere to when contributing to records of patients under the care of MHS. The standards set out in this policy do not replace standards set by professional organisations but are complementary to them.

2. RECORDING STANDARDS

2.1 General Principles

All entries must be:-

- Factual
- Objective / Non Judgemental
- Relevant
- Accurate
- Documented and validated within 24 hours (see outline of timelines overleaf)

- Dated, timed and location and duration of contact with patient (and / or carer / relative) noted e.g. appointment / interview
- Validated at end of entry
- Validated for other professional imputing
- Consecutive and contemporaneous
- Free from excessive abbreviations and jargon
- Subject to spell check

The records must identify:-

- How the information for the entry was obtained e.g. source / context
- Problems, concerns and the actions taken to rectify them
- All relevant information gained from others with source time and date of receipt
- Decision making rationale (e.g. granting of leave) underpinned by multidisciplinary consultation / involvement
- Any changes to medication
- Level of Care (Standard or CPA)
- The Care Coordinator / Lead Professional
- Whether the patient has the capacity to consent to their care and treatment
- If the patient has given consent for information to be shared, who with and for what purpose

2.2 Recording Time Frames

All recordings must be made as soon as possible after an event has occurred. Where significant risk has been identified, this will be within 24 hours. All other entries must be made within one working day of that team's operational hours.

2.3 Recording of Opinion

The recording of an opinion in the record must indicate such and include an underpinning rationale; clearly distinguishing between opinion, fact and hearsay.

2.4 Minimum Data Set

All elements of the record must be completed in accordance with the MHS Minimum Core Data Set (Appendix 7).

2.5 Validation of entries

All entries in RiO must be validated where the function exists (Progress Notes).

Validating an entry in RiO is confirmation that the information is being formally registered as truthful and factual. Registered health and social care professionals are able to validate their own entries in patient records and this should be viewed as comparable to signing a manual document. Support staff, such as health care assistants and support workers, **must** have their entries validated by a registered practitioner, as this is an indicator the information has been communicated.

Self-validation must ordinarily be completed at the time of entry wherever possible and within a maximum of 24 hours where amendments are being considered.

Where a member of staff is validating an entry made by a colleague, they are indicating that they have;

- Read the entry
- Assessed whether any further action is required
- Where further action is required, this will be detailed in a new RiO entry by the professional involved

2.6 Records of Formal Patient Meetings

Wherever possible / practicable formal patient meetings should be minuted. These records must:-

- Identify the type of meeting – e.g. professionals' meeting
- Indicate who was present and who was invited (and did not attend) along with the venue, date, time and duration
- Have decisions clearly recorded along with any dissenting views
- Be circulated to those agencies attending and those invited who did not attend
- Take into account and include written reports and views of the patient and those of significant carers
- Explicitly outline arrangements for the management of risk
- Be uploaded to the patient's RiO record

2.7 Copying of Correspondence to Patients

In order to promote the principles of the Care Programme Approach, letters about the patient should ordinarily be addressed to the patient in the first instance (in the case of CAMHS, the letter may be sent to the parent). The letter can then be copied to other involved health and social care professionals, such as the patient's GP, where required. However, there are occasions when it may not be considered appropriate for the patient to be the primary recipient; for example, if the patient lacks capacity or where it is believed the correspondence may cause unnecessary or avoidable distress.

The MHS operates on an 'opt-out' basis with regard to correspondence and so upon first contact it is important for the patient to be made aware of this standard approach, allowing the opportunity for the individual to express their views and preferences and to opt out where necessary. Whilst letters can be exchanged directly between professionals under certain circumstances, the rationale for not involving the patient should be clearly documented.

2.8 Warning Indicators / Alerts

In the interests of staff and patient safety it may be necessary to document a warning indicator / alert in a patient's RiO record.

In order to promote transparency and patient engagement, the patient should ordinarily be advised of the inclusion of a warning indicator / alert on their RiO record and the reasons for it. In the event that disclosure is not considered appropriate, a rationale must be included in the record.

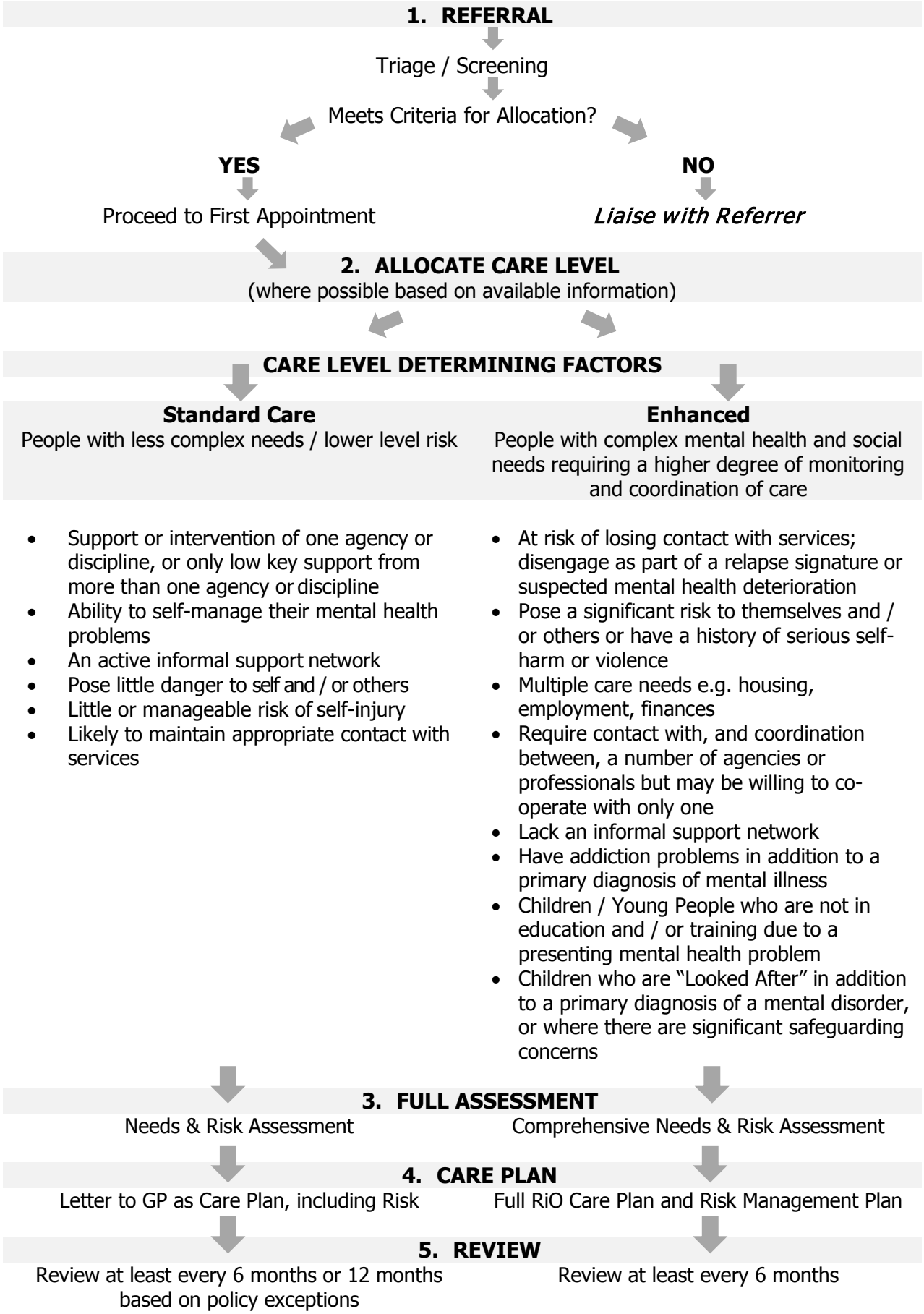
The inclusion and review of warning indicators / alerts is ordinarily the responsibility of the Care Coordinator (Enhanced Care) or the Lead Professional (Standard Care). However, there will be occasions when other registered professionals may have reason to document an alert; for example, out of hours in the event of crisis intervention. On such occasions the alert should be brought to the attention of the Care Coordinator / Lead Professional at the earliest opportunity.

Warning indicators / alerts must be subject to review at least every 6 months (at CPA Review for example) or upon transition between services or discharge from the Mental Health Service.

All warning indicators / alerts entered on the patient's record must be compliant with GDPR and Caldicott Principles. Practitioners should discuss the inclusion and review of alerts with their line manager in management supervision.

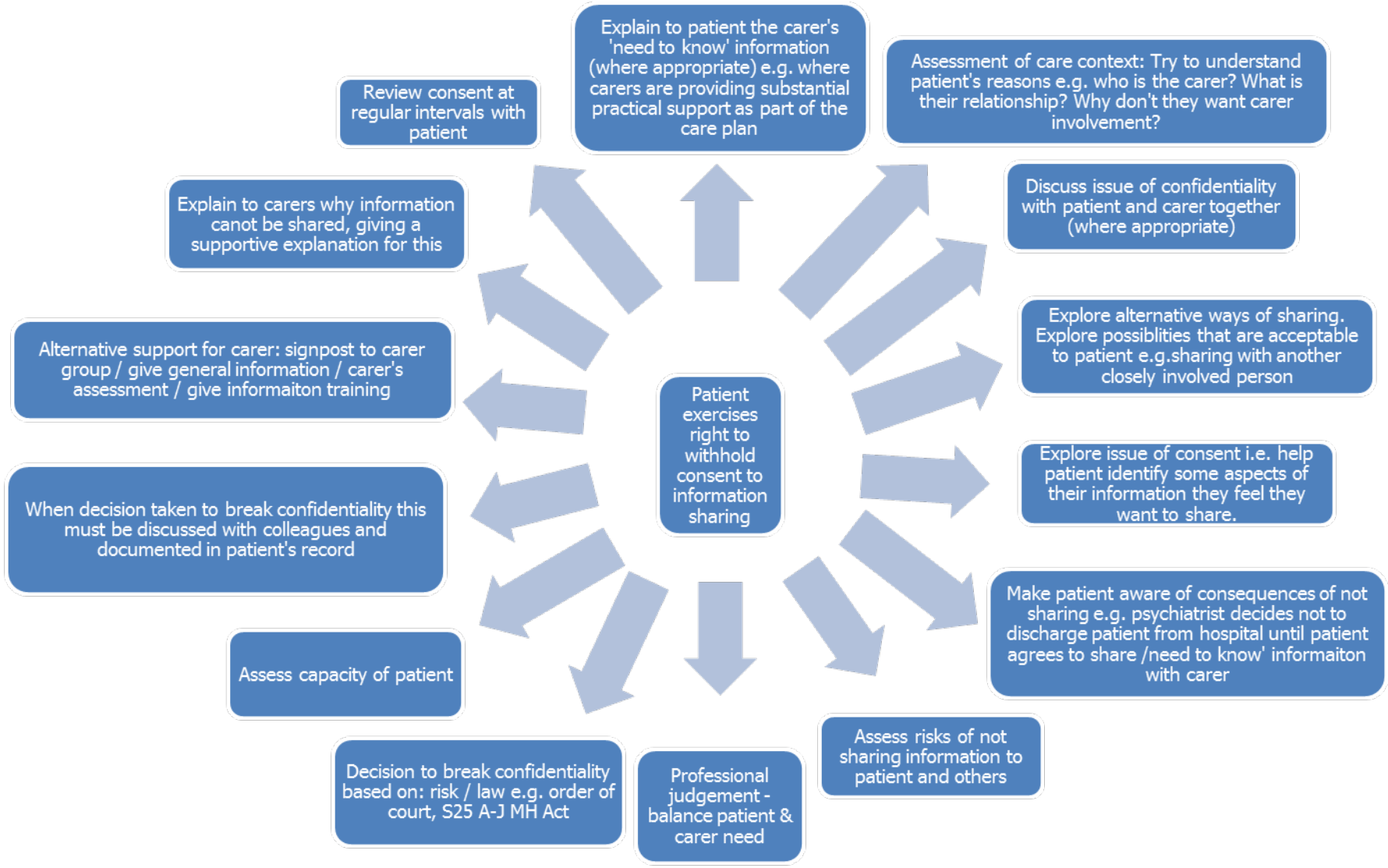
Appendix 2

Care Programme Approach Flowchart



Appendix 3

Possible strategies for professionals when patients exercise their right to withhold consent to share 'need to know' information with carers (based on Figure 7 NCCSDO 2005)



Appendix 4

Care Programme Approach (CPA) Enhanced Care Formal Review
Patient Feedback

This questionnaire will help us understand if you were involved in your CPA Review Meeting as much as you would like to be. We would be grateful if you take a few minutes to complete it. This will help us improve your experience of the CPA process in the future. Please circle your response to each question. Thank you.	
1. Did you feel involved in the organisation of your meeting?	
YES	NO
2. Were you excluded from any part of your CPA meeting?	
YES	NO
If yes, do you know why?	
3. Did you discuss before the CPA meeting the arrangements, including the venue?	
YES	NO
4. Did you discuss with your Care Coordinator who you wanted to attend the meeting?	
YES	NO
5. Did you discuss the points for the agenda before the meeting?	
YES	NO
6. If you wanted to write a report were you supported to do this by your care team?	
YES	NO
7. Were you given the opportunity to raise any points in your CPA review meeting?	
YES	NO
8. Were you happy with how the meeting was chaired?	
YES	NO
9. Were you able to meet with the people invited to your CPA before the meeting started?	
YES	NO
10. Did everyone who had submitted a report attend the meeting?	
YES	NO
11. Were goals and action plans agreed?	
YES	NO
12. Do you feel that you were directly involved in the discussion of any reports submitted?	
YES	NO
13. Were you happy that you could understand the content of any reports?	
YES	NO
14. Did everyone attending the CPA meeting behave in a respectful manner and respect other people's involvement in the meeting?	
YES	NO
15. Did you feel involved in the action plan which came from the meeting?	
YES	NO
Please add any other comments in this section.	

Please sign below to confirm that you have been given this questionnaire after your CPA Review Meeting, regardless of whether you fill in the questionnaire, many thanks.			
Name		Signature	
Care Coordinator		Date	

Care Coordinators: Please upload to RiO

Appendix 5

Care Programme Approach Policy Audit Tool for Standard Care and Enhanced Care			
Patient's RiO number		Patient's initials	
CPA Level	**STANDARD**	**ENHANCED**	

SECTION A CPA Status			
Policy Standard		**Standard Met**	**Comments / action required**
1	Is the level of care recorded (Standard Care or Enhanced Care)?	YES / NO	
2	Is there a named Lead Professional (Standard Care) or Care Coordinator (Enhanced Care)?	YES / NO	

SECTION B Needs Assessment			
Policy Standard		**Standard Met**	**Comments / action required** (if N/A state why)
3	Does the record identify carers who provide regular and substantive care?	YES / NO N/A	
4	Is there a documented needs assessment appropriate to the patient's stage in the pathway?	YES / NO N/A	
5	Does the assessment include a full history and relevant biological, psychological and social factors?	YES / NO N/A	
6	Does the assessment incorporate the patient's views?	YES / NO N/A	
7	Is there evidence of carer involvement in the assessment process?	YES / NO N/A	
8	Is there a clear summary in the assessment of the patient's strengths, skills and existing coping strategies?	YES / NO N/A	

SECTION C Risk Assessment and Risk Management Plan			
Policy Standard		**Standard Met**	**Comments / action required**
9	Is there a current risk assessment appropriate to the patient's stage in the care pathway?	YES / NO N/A	
10	Does the risk assessment incorporate the patient's views?	YES / NO N/A	
11	Is there evidence of carer involvement in the risk assessment process?	YES / NO N/A	
12	Is there a risk management plan informed by the outcome of the assessment?	YES / NO N/A	
13	Has the risk assessment and risk management plan been shared with the patient (if no, is a clear rationale documented)?	YES / NO N/A	
14	Has the risk management plan been shared with appropriate others, including nominated carer(s)?	YES / NO N/A	
15	Is there evidence the risk assessment has been updated? (e.g. due to changes / incidents or at least on a 6 monthly basis)	YES / NO N/A	
16	Is there evidence of appropriate use of the Risk Incidents function on RiO?	YES / NO N/A	
SECTION D Care Planning			
Policy Standard		**Standard Met**	**Comments / action required**
17	Is there a documented care plan? (CPA – full use of RiO Care Plan; Standard Care – letter to GP)	YES / NO N/A	
18	Does the care plan address needs identified at assessment and /or subsequent reviews?	YES / NO N/A	
19	Does the care plan show clear description of problems / needs?	YES / NO N/A	

20	Does the care plan clearly identify interventions, actions, frequency and responsibility?	YES / NO N/A	
21	Is there evidence of patient involvement in developing the care plan?	YES / NO N/A	
22	Is there evidence of carer involvement in the development of the care plan?	YES / NO N/A	
23	Is there evidence that the patient has been offered a copy of the care plan?	YES / NO N/A	
24	Is there evidence that all those involved in the care of the patient have received a copy of the plan?	YES / NO N/A	
25	Is there evidence that planned interventions have / are being carried out?	YES / NO N/A	
26	For patients discharged from the **inpatient service** – has a discharge summary been sent to the GP within 24 hours and a more detailed summary sent within 5 days of discharge?	YES / NO N/A	
27	For patients discharged from the **inpatient service** – has a follow up appointment taken place within 3 days?	YES / NO N/A	
SECTION E Review			
Policy Standard		**Standard Met**	**Comments / action required**
28	**Community** - is there evidence that care has been reviewed on a minimum of a 6 monthly basis (or 12 months in the case of identified policy exceptions)? **Inpatients** – is there evidence of a CPA Review taking place prior to discharge?	YES / NO N/A	
29	Is there evidence that the patient has been involved in the review?	YES / NO N/A	
30	Is there evidence of carer involvement in the review?	YES / NO N/A	

31	**Enhanced Care only** - Has the patient been given the opportunity to complete the CPA Review Feedback Questionnaire?	YES / NO N/A	

Additional Observations (including compliance with record keeping standards)**:**

Service Name			
Lead Professional / Care Coordinator			
Name of person completing the audit			
Signature:		**Date**	

#	Summary of Actions Required	Responsible	Target Date

Appendix 6

MINIMUM STANDARDS FOR RECORDS AND RECORD KEEPING
AUDIT TOOL

RiO Record No:		**Auditor**	
Care Coordinator / Lead Professional		**Date**	

#	Standard	Compliance		Comments
1	All demographic information is recorded	YES	NO	
2	CPA level is identified	YES	NO	
3	Care Coordinator / Lead Professional identified	YES	NO	
4	Entries are accurate / objective / factual	YES	NO	
5	Entries include the date of intervention	YES	NO	
6	Entries include the time of intervention	YES	NO	
7	Entries include the location of intervention	YES	NO	
8	Entries include the duration of intervention	YES	NO	
		N/A		
9	Entries identify how the information was obtained (source)	YES	NO	
10	Entries are free from jargon and abbreviations / acronyms	YES	NO	

11	Entries are consecutive and contemporaneous	YES	NO	
12	Entries are made within 24 hours / one working day	YES	NO	
13	Recording of opinion is clearly indicated and explained	YES	NO	
14	Entries are validated	YES	NO	
15	Record includes if the patient has capacity or not	YES	NO	
		N/A		
16	Record includes consent to share information	YES	NO	
		N/A		
17	Correspondence is sent to the patient (or where this is not the case a valid rationale is recorded)	YES	NO	
18	Warning indicators / alerts are considered appropriate	YES	NO	
		N/A		
19	Warning indicators / alerts have been subject to review	YES	NO	
		N/A		
TOTAL		**YES**	**NO**	
% Compliance				

Actions taken as a result of audit: Signature: Date:

Appendix 7

Minimum Data Set

Number of people open to specialist Mental Health Services (MHS)
Number of people on CPA
Number of people on enhanced CPA for 12 months or more
Number of people open to inpatients
Number of people currently detained under the Mental Health Act
Number of people placed in off Island placements
Number of people placed in off Island placements for more than 3 months
Number of people open to a Psychiatrist with a recorded diagnosis
Number of people aged 18-69 on CPA in employment
Number of people discharged from Inpatient Services
Number of people discharged from Community Services
% of people discharged from inpatient services with completed 5 day follow up
Number of patients recorded as AWOL from inpatient services
Number of emergency admissions
Number of re-referrals
Number of people with a recorded ethnicity
Number of people with a record accommodation status
Number of people with a recorded Risk Management Plan
Number of admissions to inpatient services
% breakdown of referral source to all Mental Health teams
Rates of attendance to include DNA, Cancellations, Attended and Un-outcomed
Average length of stay for open inpatients
% bed occupancy for each inpatient unit
Number of people recorded as Section 115
% split of open patients by postcode
% of under 18s record as in education
% split of people open to MHS by gender
% split of people open to MHS by age group (under 18, 18-35, 36-69, 70+)
Number of incidents reported
Number of open patients with recorded alcohol and/or drug abuse
Number of referrals made to Mental Health Services