Best Practice Statement ~ March 2009

Admissions to adult mental health inpatient services
NHS Quality Improvement Scotland is committed to equality and diversity. We have assessed this Best Practice Statement for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For a summary of the equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

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Introduction

NHS Quality Improvement Scotland (NHS QIS) leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions:

- providing advice and guidance on effective clinical practice, including setting standards
- driving and supporting implementation of improvements in quality, and
- assessing the performance of the NHS, reporting and publishing the findings.

In addition, NHS QIS also has central responsibility for patientsafety and clinical governance across NHSScotland.

Key principles of best practice statements

A series of best practice statements has been produced within the Practice Development Unit of NHS QIS, designed to offer guidance on best and achievable practice in a specific area of care. These statements reflect the current emphasis on delivering care that is patient-centred, cost-effective and fair. They reflect the commitment of NHS QIS to sharing local excellence at a national level.

Best practice statements are produced by a systematic process (see page 3), and underpinned by a number of key principles.

- They are intended to guide practice and promote a consistent, cohesive and achievable approach to care. Their aims are realistic but challenging.
- They are primarily intended for use by health professionals, including nurses, midwives, allied health professionals, and the staff who support them. This extends to non-statutory and voluntary services.
- They contribute to provision of ‘the most appropriate care, at the most appropriate time by the most appropriate person, delivered in the most appropriate place’.
- They are developed where variation in practice exists and seek to establish an agreed approach for practitioners.
- Responsibility for implementation of these statements rests at local level.

Best practice statements are reviewed, and, if necessary, updated after 3 years in order to ensure the statements continue to reflect current thinking with regard to best practice.

Best practice statements are also accessible electronically via the NHS QIS website (www.nhshealthquality.org).

Supporting implementation

Comments on best practice statements are very much welcomed. We are always keen to hear from anyone who has been involved with using the statements in their own area of practice. In particular, we would like to hear about specific successes or challenges relating to implementation and impact on quality of care provision.

Any information provided will be used to inform the next review of the statement.

Please forward any comments to: qis.bestpracticestatements@nhs.net

Privacy note: We will only use your email details to reply to your comment. Your address will not be passed on to any third parties.
Key stages in the development of best practice statements

1. Establish working group.
2. Topic selection and scoping process.
3. Determine focus and content of statement.
   - Review evidence for relevance to practice.
   - Determine how patients’ views will be incorporated.
4. Establish reference group to advise on consultation drafts.
5. Review literature on topic.
   - Source grey literature.
   - Ascertain current policy and legislation.
   - Seek information from manufacturers, voluntary groups and other relevant sources.
6. Review and update process.
   - Identify new research/findings affecting topic.
   - Consider challenges of using statement in practice.
   - Wide consultation process.
8. Review and revise statement in light of consultation comments.
10. Publish and disseminate statement.
Best practice statement: Admissions to adult mental health inpatient services

This best practice statement has been reviewed and revised to reflect developments in policy and practice within mental health. The work has been led by NHS QIS in collaboration with multidisciplinary working and reference groups. While the aim of the statement is to offer guidance on practice to health professionals within adult mental health inpatient services, the emphasis throughout is on multidisciplinary, inter-agency working and collaboration. The document extends to practice involving home treatment teams, intensive community support services, community-based crisis intervention teams, community mental health teams and health professionals within the primary care setting and those from the voluntary sector.

The statement also endorses the principles laid down in key documents such as: Realising Recovery; A Capability Framework for Working in Acute Mental Health Care; Standards for Integrated Care Pathways for Mental Health (Standards for ICPs); The 10 Essential Shared Capabilities for Mental Health Practice Learning Materials (Scotland) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (MH(S)A). It also reflects the importance of working in partnership with patients, carer(s) and relevant others building on their experience, expertise and strengths to aid recovery and maintain mental health and physical wellbeing.

The focus of the statement is admission to adult mental health inpatient services generally providing care for adults aged between 16 and 65 years of age. While the principles may be applied to other specialist services, the statement does not address specific needs within, for example, child and adolescent mental health, elderly and learning disability services. Nor does it specifically attempt to address the challenges faced by remote and rural areas.

It is, however, acknowledged that with regard to children and young people there is under-provision of specialist facilities in Scotland with the potential consequence of children and young people being admitted to adult mental health inpatient services. This scenario is not exclusive to Scotland as reflected in the National Service Framework for Children Young People and Maternity Services: The Mental Health and Psychological Well-being of Children and Young People: Standard 9 which states: ‘Due to the insufficient numbers of adolescent beds, some young people are being cared for inappropriately in adult psychiatric beds. In addition, children and young people who are suffering from psychotic illness or who have complex, persistent and severe behaviour disorders and who first present in accident and emergency departments may then be admitted to paediatric wards. A children’s ward is not usually the best place for such patients, who may need to be in a children’s or adolescent psychiatric unit or other appropriate, jointly agreed, alternative facilities as soon as possible’.

It is important to consider this issue further as Section 23 of the MH(S)A contains new provision for the care of people under 18 who need admission to hospital for the treatment of a mental disorder, regardless of whether the person is subject to informal or compulsory admission. Under the MH(S)A, it is recognised that NHS boards have a duty to provide ‘such services and accommodation as are sufficient for the particular needs of that child or young person’. The specific challenges faced in implementing these services are highlighted in the review of inpatient services, Needs Assessment Report on Child and Adolescent Mental Health, and Depression in Children and Young People: Identification and Management in Primary, Community and Secondary Care.

It is essential that health professionals are aware of the legal requirements and documentation which ensure the best quality of care is provided to those in this situation and that organisations continue developing networks of care in each locality promoting ‘collaborative working between services such as therapeutic fostering, pupil referral units, secure units, adolescent inpatient units and children’s homes’.

Similar challenges are evident regarding care for mothers experiencing mental health difficulties and their infants. Again, provision is made in
Section 24 of the MH(S)A\textsuperscript{2}: Provision of Services and Accommodation for Certain Mothers with Postnatal Depression, with regards to those who experience postnatal depression and require to be admitted to hospital who wish, if able, to care for their children whilst an inpatient. Further guidance on perinatal good practice can be found in Quality network for Perinatal Mental Health Services: Standards for Mother and Baby Inpatient Units\textsuperscript{11}.

Recommendations on more general information for staff, eg Healthier Scotland, Well Scotland, National Care Standards, etc, and access to training aids are detailed within the Info Scotland website (\url{www.infoscotland.com/infoscotland/servlet/controller}) and NHS Education for Scotland (NES) Educational Solutions for Workforce Development website (\url{www.nes.scot.nhs.uk/nursing/mentalhealth/}) and included in documents such as Promoting Health, Supporting Inclusion\textsuperscript{12} and The Royal College of Nursing Journal of Mental Health Practice\textsuperscript{13}.

The importance of good and effective communication, access to and the sharing of information across services and all disciplines, is crucial in attaining best practice for people entering these services, and is echoed throughout the document. It is identified in action plan 23 of the National Review of Mental Health Nursing\textsuperscript{14}, that ‘a more robust climate of learning, development, evaluation and research must be developed across the mental health nursing community in NHSScotland’. This recommendation extended to creating and maintaining a database of positive and innovative practice in mental health. In response, NHS QIS has developed the national multidisciplinary database PIRAMHIDS - Positive and Innovative Resources: A Mental Health Interactive Database (Scotland): \url{www.piramhids.com}. This is an open access web-based resource that enables sharing of examples of evidence-based practice in mental health. Contribution to the database is actively encouraged.

This best practice statement forms part of a range of NHS QIS initiatives addressing issues in mental health. While the focus of this statement is admissions to adult mental health inpatient services, it is fully intended that it will complement other parts of the NHS QIS work programme. The statement is developed with specific cognisance of the Standards for ICPs\textsuperscript{4}, amongst others referred to in this document. This statement will be a key document in developing policy and practice to support healthcare governance at local level and inform practice which contributes to meeting Standards for ICPs\textsuperscript{4} accreditation.

The wide range of advice and guidance produced by NHS QIS reflects the breadth of healthcare activity and diverse needs of NHSScotland. All information produced by NHS QIS shares the common goal of improving patient care either directly or indirectly.
Format of statement
The statement is divided into six sections covering:

Section 1: Pre-admission/initial assessment of need
Section 2: Risk assessment and management
Section 3: Admission to hospital – exchange of information
Section 4: Assessment and planning for recovery
Section 5: Holistic assessment of psychosocial, occupational and physical needs and strengths
Section 6: Planning recovery and working towards discharge

Key points highlight the core principles that are reflected throughout the statements. Each section contains a table corresponding to the what, why and how of best practice, i.e., the statement, the reason for the statement and how to achieve the statement or how to demonstrate that it is being achieved. The underpinning philosophy of the statement and/or explicit skill requirements to achieve best practice are identified. Key challenges, relating to each specific statement, are identified and reflect existing examples of best practice and highlight areas that may require specific action or development.

Promotion of best practice at local level is supported by the Mental Health Collaborative and Acute Inpatient Forums with representation from key stakeholders involved in delivering acute inpatient care. For further information, please visit the Scottish Government website (www.scotland.gov.uk).

How can the statement be used?
This best practice statement can be used in a variety of ways, although primarily it is intended to serve as a guide to best practice and promote a consistent and cohesive approach to care. The statement is intended to be challenging but realistic and can be used:

- as a basis for developing and improving care directly and indirectly
- to stimulate learning among multidisciplinary mental health teams
- to promote effective multiprofessional team working and enhance partnerships with patients, carer(s) and relevant others
- to serve as a measure of quality in admissions procedure in mental health, and
- to stimulate ideas and priorities for research.

It is advocated that the statement is interpreted and considered with the underpinning principles that care providers are approachable, courteous and exhibit an obvious willingness to respect and listen to the person in their care.¹⁵
Please note:

Responsible medical officer

For the purpose of this document, where responsible medical officer (RMO) is referred to, it is intended to encompass the consultant psychiatrist or deputy and/or general practitioner (GP). It is also highlighted that the RMO is part of the multidisciplinary team, however, throughout the statement there are occasions where they are mentioned specifically because of a particular expectation.

Consent and confidentiality

Throughout the statement reference is made to consultation, discussion and information sharing with carer(s) and relevant others including inter-agency and voluntary sector working. It should be noted that any such interaction and communication is advocated on the premise that all formal and required consents are sought, obtained and documented appropriately, principles of confidentiality are adhered to and that capacity to consent is considered. The RMO should always be consulted. In addition, all staff are expected to comply with their specific professional code of conduct and are personally accountable for their practice.
Section 1: Pre-admission/initial assessment of need

Key points:

1 Positive reasons for and perceived benefits arising from admission to acute inpatient care should be evident. Admission should be agreed as the most appropriate option for patient care and treatment following careful consideration of alternative services that may also potentially be capable of meeting an individual’s and carer(s) needs.

2 The underpinning philosophy of inpatient care is that the service provider can meet the needs of the individual as advocated in the Millan Principle of Reciprocity6.

3 Wherever possible and when safe to do so, pre-admission assessment should take place in a private and safe environment, outwith the admission ward.

4 It is acknowledged that while gathering relevant information during assessment is crucial, health professionals require awareness and exhibit sensitivity in relation to the situation and presenting factors at the time of assessment. Consideration should be given to what is most relevant to meet the needs and to utilise the strengths of the person being assessed, resulting in reduced risk of causing additional stress from the process of assessment in itself. Where there are local agreements about essential elements of the assessment, these should be followed wherever possible.
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<th>Statement 1(a)</th>
<th>Reason for statement</th>
<th>How to demonstrate statement is being achieved</th>
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| Health professionals conduct an initial assessment of need by means of clinical interview and the review of all available information. This process will involve formation of good therapeutic alliance with the person being assessed, carer(s) and relevant others. | Multidisciplinary working can both model and facilitate a partnership whereby assessment and holistic care planning for recovery can be achieved with the patient, carer(s) and relevant others. | There is documented evidence of initial assessment detailing the following:  
  • current and past mental state and presenting problems  
  • current and past interventions  
  • inclusion of patient, carer(s) and relevant others in the decision-making process (including carer(s) and relevant others risk assessment)  
  • mental health needs  
  • assessment of alcohol or substance misuse  
  • physical needs  
  • personality needs  
  • psychological needs  
  • social needs  
  • spiritual needs  
  • pharmacological needs  
  • functional skills/needs  
  • occupational needs  
  • alternatives to admission identified and reasons for unsuitability recorded  
  • proposed benefit from admission  
  • patient’s consent to admission (when relevant, ie not subject to compulsion under the MH(S)A)  
  • an agreed initial recovery plan established between the patient and health professionals (where appropriate, ie if circumstance, presentation and capacity of the patient allows), and  
  • a patient’s self-reporting of good positive engagement with health professionals.  |

**Key challenges:**

- Ensuring adequate and timely access to and use of previous assessment information (physical, psychological, mental health and social functioning) from statutory (primary and tertiary care) and voluntary agencies to aid assessment.
- Development of close working relationships between inpatient services and community-based services to improve sharing of information. Services include generic community mental health teams (CMHTs), intensive community support services, crisis resolution teams, home treatment teams, ‘on-call’ medical staff, NHS 24, etc.
- Ensuring accident and emergency (A&E) departments in hospitals have a ‘liaison nurse’, ie staff with additional specialist skills in mental health who could deal sensitively with cases involving mental distress or self-harm.
- Developing systems of working that accommodate joint assessment practice, recognising potential for workforce implications.
- Development of conflict resolution strategies in the event of significant differences of opinion between health professionals or between patient and care teams.
## Statement 1(b)

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<tr>
<th>Reason for statement</th>
<th>How to demonstrate statement is being achieved</th>
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<td>All options including inpatient admission and community-based care should be considered, explored and discussed with the patient, carer(s) and relevant others. (Communication with RMO when contactable is advocated throughout the initial assessment period as is involving other health professionals who have current and ongoing involvement with the person being assessed.)</td>
<td>There is documented evidence of:</td>
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<td>• the range of options that have been considered and any information given to the patient, carer(s) and relevant others including the format in which information was provided</td>
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<td></td>
<td>• patient’s reactions to and perception of range of options explored</td>
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<td></td>
<td>• carer(s) and relevant others reactions to and perception of options explored</td>
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<tr>
<td></td>
<td>• communications with, and outcomes or recommendations by RMO</td>
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<td></td>
<td>• communication and opinion sought from other health professionals that have ongoing contact with the person being assessed</td>
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<td></td>
<td>• outcomes of initial assessment including initial management plans, and</td>
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<td>• outcomes of above deliberations which clearly indicates reasons for inpatient admission</td>
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## Key challenges:

- Ensuring the role and purpose of the mental health inpatient setting is understood by health professionals and patient, carer(s) and relevant others.
- Encouraging service design that is ‘needs-led’ and includes public involvement, ensuring alternatives to admission are available.
- Ensuring that information is delivered in a way that is comprehensible and takes into consideration issues of equality and diversity.
- Instilling and maintaining recovery-focused philosophy by all concerned.
Key challenges:

- Ensuring adequate systems of communication and information access are in place across multidisciplines and multi-agencies allowing timely, relevant information to be ascertained which may inform the initial assessment outcomes.*

- Mental health inpatient care is an area of practice where the ability to deliver care and services based on the rights-based principles of the MH(S)A may be particularly tested and challenged. It is also an area in which mental health nurses sometimes feel compromised in their ability to deliver rights, principles and recovery-focused care. Challenging the mind set of health professionals and influencing culture is key.

- To ensure all inpatient units develop models of care based on the principles of the MH(S)A and the recovery approach.

* It should be noted that consent may not be required in specific situations where child protection issues indicate requirement to, for example, share/obtain information against the wishes of the individual being assessed.
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<th>Statement 1(d)</th>
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| Needs of carer(s) and relevant others must be assessed in an empathetic manner with sensitivity to the situation. | Carer(s) and relevant others can be physically, mentally and emotionally exhausted, confused and at a loss as to how best to continue to support an individual. They may also require respite from a situation and may have difficulty seeking help. | There is documented evidence that:  
• carers(s) and relevant others are consulted, their views heard and needs identified  
• any potential conflict that may be detrimental to the individual's mental health (person being assessed for admission) or jeopardise stability of their social circumstance is highlighted  
• potential difficulties which may arise from decision in relation to what interventions are offered and where, for example remain at home, admit to hospital, alternative respite facility, etc, are highlighted and what steps have been taken to manage this  
• implications for carer(s) and relevant others, if assessed person is not admitted, have been considered, and  
• that any potential conflict has been explored, highlighted and an appropriate plan to manage this has been put in place. |

There is potential for conflict between the person being assessed and their carer(s) and relevant others which may jeopardise relationships and ability to provide support in the future.

An increased emphasis on the need to acknowledge the role of carer(s) and respect their experience, identify their needs and ensure support is advocated within the Millan Principles⁴ and the Standards for ICPs⁴.

There is potential for conflict between the person being assessed and their carer(s) and relevant others which may jeopardise relationships and ability to provide support in the future.

Key challenges:

• Facilitating carer consultation in a safe and sensitive manner whilst offering reassurance to the individual being assessed.
• Developing appropriate systems of record-keeping ensuring that documented information is accessible, multidisciplinary and able to ‘travel’ with the individual through the journey of assessment and intervention.
• Developing recording and information governance systems that ensure RMO is involved in any decision regarding a patient requesting access to their own records, as carer(s) opinions and others giving information may be viewed with potential negative consequence.
• Developing the skill base of health professionals to manage situations where there is potential or actual conflict of interests between the views of staff and patient in relation to care or treatment. This may extend to potential conflict between what is perceived to be best for a patient and not agreed by carer(s) or relevant others.
Section 2: Risk assessment and management

Key points:

1. Risk assessment and management is integral to every stage of the admission process and should be a routine part of inpatient care.

2. Risk assessment and management should be viewed as a dynamic, ongoing process, not a single event/episode on admission.

3. Observation levels determined by risk assessment require explicit policies and procedures on reviewing observation levels.

4. Accurate risk assessment helps reduce risk of suicide or deliberate self-harm. The HEAT target from Delivering for Mental Health: (Target 2-Commitment 7) specifies reduction of suicide rate between 2002–2013 by 20%. Working towards HEAT targets is supported by the Mental Health Collaborative.

5. The Department of Health commissioned a review on the evidence of risk assessment that reflected clinical priorities. The outcome of the review clearly maintained that risk assessment tools should support rather than replace clinical judgement.


7. Acknowledgement should be given to the potential benefits to a patient when a robust risk assessment and management plan is carried out and developed, especially if compiled collaboratively.
### Statement 2(a)

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<td>An initial risk assessment should always be carried out in the pre-admission phase. This is particularly important for those with no existing contact with mental health services. The assessment at this stage will be part of an ongoing risk assessment and risk management plan that will continue to evolve throughout the admission process, the inpatient stay and beyond. This should be developed and delivered in collaboration with the patient, carers(s) and relevant others and should take into account both historical (static) and current (dynamic) risk factors. For those with existing contact with mental health services, risk assessment should be viewed as progressive and fluid ensuring community-based knowledge is considered, reviewed, communicated and documented appropriately and that the RMO is informed and consulted at the earliest possible opportunity.</td>
<td>There is documented evidence:  - that risk assessment, including concurrent physical health needs, has been carried out by the multidisciplinary team specifying the name and role/designation of staff undertaking the assessment  - that risk factors are highlighted and appropriate action taken accordingly, e.g. self-harm, violence towards others, absconding, sexual vulnerability, gender treatment, non-concordance, occupational risk, physical neglect, nutritional deficit, vulnerability, threat to vulnerable groups and risk related to medication  - that any specific risks such as emotional or physical risk to children in the patient’s care are highlighted  - of specific communication with RMO specifying their opinion based on clinical judgement, direction and/or instruction  - that the views of the patient, carers(s) and relevant others are considered  - how content of risk assessment detail is communicated to others including the patient, carer(s) and relevant others, health professionals, informal carer(s), multi-agencies, etc  - of any rationale for risk assessment and management plans not being shared with the patient, highlighting RMO comment/instruction  - of how the risk assessment is being monitored, evaluated and audited on completion, and  - of all risks that have been clearly identified, and of appropriate management plans that have been put in place to deal with these. If or where this has not been achieved, a clear explanation should be documented. This information should then be communicated to all relevant staff – especially where there is a need to continue to work towards establishing further safety mechanisms, in keeping with an ongoing risk management plan.</td>
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<td>Risk assessment and management is crucial for determining the needs of the patient in order that optimum levels of care can be provided, reducing the potential of negative outcomes. Risk is appropriately assessed and managed. Assessment is enhanced by multiple sources of information including information from GP and health professionals within the primary care setting, where relevant. Quality of assessment information and professional decision-making can be improved through multidisciplinary, multi-agency collaboration, through discussions and joint care planning. Risk assessment enables the initiation and maintenance of appropriate risk management strategies. There is greater consistency when risk assessment moves with the patient through the transition of care, from community to inpatient setting and back to community on discharge, forming an evolving dynamic system. This in turn enhances quality of care through provision of a seamless service. Risk assessments are used as benchmarks even after a patient is discharged and informs consideration of the need for admission in the future. They can also reflect improvements in health.</td>
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### Key challenges:

- Developing principles underlying risk assessment and management that are consistent within and across NHS boards.
- Developing systems of reporting and audit with regards to risk management to inform benchmarking mechanisms reflecting relevant targets.
- Promoting a culture of recovery-focused care within the acute setting and working in partnership with the patient, carers(s) and relevant others, influencing overall attitudes to focus on positive risk-taking as opposed to predominant risk aversion.
- Development of multiprofessional/multi-agency, i.e. health and local authority risk assessment documentation and systems which facilitate timely and effective sharing of information.
- Ensuring all staff are trained in ‘promoting recovery, safety and therapeutic assessment and therapeutic risk management’. 

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### Statement 2(b)

The patient, carer(s) and relevant others should be fully involved in the development of a risk profile and management plans when the patient is well enough or when staff are able to involve them. This involvement will include consideration of the patient’s role in positive risk-taking based on their capability.

### Reason for statement

‘If a positive and open relationship exists between the user and their key worker, risk management can be a positive process and a vital step towards recovery’. This empowers the patient to retain ownership of their own recovery and promotes acceptance of their role and personal responsibilities. Such responsibilities must be balanced against level of ill health and capability.

Risk assessment and management is not a passive experience and should be viewed as an integral aspect of the recovery process.

### How to demonstrate statement is being achieved

There is documented evidence concerning the way the patient, carer(s) and relevant others have been involved or not in the formulation of risk profiles/management plans.

If the patient is not included in this process, the time of assessment and the rationale for this is recorded. The clinical judgement of the RMO is considered and also recorded.

Future steps to re-engage the patient in the risk assessment and management process should be considered and perhaps repeated at a later, more amenable time.

### Key challenges:

- Promoting the process of risk management as a therapeutic tool in a patient’s recovery.
- Ensuring health professionals from all disciplines can ‘sensitively apply procedures and practices in the prevention and management of violence and aggression by actively and meaningfully involving people in a shared responsibility for assessment of risk and risk-taking’, as advocated in A Capability for Working in Acute Mental Health Care.
- Engendering attitude of participation in risk assessment and management as inherent to the role of each mental health practitioner’s routine practice, ie not sole responsibility of the RMO or psychologist, eg all practitioners have a key role to play in this.
- Improvements in strategies to increase ‘whole system’ ownership of suicide reduction HEAT target, ie performance management of this is not the sole responsibility of managers – it’s everyone’s business.
### Statement 2(c)

All patients are assessed using a combination of formal**
assessment measures and structured clinical judgment to
determine their level of risk.

### Reason for statement

Enhances equality in care provision ensuring that core criteria
relating to risk assessment are met and supported by the provision of
a range of risk assessment tools, for example, those advocated within
the Standards for ICPs toolkit\(^\text{27}\).

### How to demonstrate statement is being achieved

There should be recorded evidence of risk assessment including:
- those involved in the risk assessment
- details of the nature of information shared, with whom it has
  been shared and how this was undertaken
- the person with responsibility for review, the planned timeframe
  for this and how this will be monitored, and
- observation levels derived from risk assessment and set by the
  RMO (informed by multidisciplinary team) have been discussed
  with the patient, carer(s) and relevant others.

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**Key challenges:**

- Development and application of recognised and validated risk assessment tools.
- Developing opportunities and methodologies for testing the validity of risk assessment tools.
- Supporting staff in acquiring the skill of risk assessment\(^\text{26}\).

**All formal risk assessment measures require specific training prior to use.**
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<th>Statement 2(d)</th>
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<td>The development of risk assessment and management plans should reflect the patient’s strengths and acknowledge: ‘the patient’s personal accounts of recovery and factors identified by them as helping or hindering their recovery process’².</td>
<td>Health professionals have a role ‘within acute care in supporting people’s recovery journeys by forming positive and optimistic relationships, which build on people’s strengths’³. Every time a problem is identified, a strategy should be suggested and discussed, building on the positive skills of the patient. The emphasis should always be on a recovery approach and on the next stage in developing the patient’s ability to cope when they are feeling vulnerable or having difficult demands placed on them².</td>
<td>There is a recorded risk assessment and management plan which includes identification of a patient’s strengths as well as personal and shared responsibilities for assessment of risk and risk-taking².</td>
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**Key challenges:**

- Translating risk assessment information into agreed and meaningful risk management plans which support inclusion of patient role and responsibility. Education for staff and patients may be required.
- Ensuring that care needs are balanced against risk and emphasis placed on positive risk management.
- Changing attitudes and culture within admission ward from being a place of safety to one of safety, therapeutic activity and where a person’s recovery is supported by positive risk-taking.
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<th>Statement 2(e)</th>
<th>Reason for statement</th>
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<td>Risk assessment should be carried out within a team, allowing sharing of information and application of different perspectives. It should not be unidisciplinary and must be ongoing in response to changes in a person's physical/mental condition, or social circumstances.</td>
<td>‘Risk assessment and management is a complex process involving objective data, data from third parties and the judgement of the clinicians involved’. That this approach is deliberately intended to guard against ‘professional (subjective) bias’ and a ‘static/non-dynamic’ approach to risk assessment and formulation of management plan. ‘No single worker has the ability to detect, assess severity of, and make arrangements to minimise risk – a systematic and co-ordinated approach is necessary’.</td>
<td>There is documented evidence of:  - multidisciplinary risk assessment and management planning, and of details about who has been involved with the risk assessment  - how and what information has been shared  - what consents have been sought and agreed  - who will review and in what timeframes, and  - multidisciplinary deliberation and formulation of risk.</td>
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**Key challenges:**
- Promoting use of risk assessment tools through methods such as use of standardised admission packs which should be aligned to generic or condition specific standards within the Standards for ICPs.
- Developing single systems of recording information to enhance continuity of care and approach.
- Sharing views on risk and reaching a consensus viewpoint.
- Establishing a mechanism for conflict resolution.
Statement 2(f)

The RMO should indicate what level of observation is required having considered all assessment information. This must be appropriately discussed with the patient, carers(s) and relevant others and communicated to all members of the care team, resulting in an appropriate recovery plan being developed.

Reason for statement

Observation is a process that ensures close monitoring of, and therapeutic engagement with, someone who needs (for a period of time) intensive care and support. It is a formal, structured process and, therefore, is fundamentally different from the normal monitoring of patients within a ward or care setting.

The purpose of observation is to ‘provide a period of safety, during temporary periods of distress with observation levels set at the least restrictive level, for the least amount of time, in the least restrictive setting’.

How to demonstrate statement is being achieved

There is documented evidence of:
- a specifically assigned observation level
- ongoing risk assessment and management plan
- therapeutic engagement during periods of increased observation
- current observation status with review time and date
- content of RMO instruction and rationale for changing the level of observations, and
- the patient having been educated and informed about the enhanced observation process, eg patient information booklet, frequently asked questions section, etc.

Key challenges:

- Ensuring robust communications systems are in place to promote and accommodate timely and appropriate information sharing, with specific regard to the dynamic nature of assessment and review and the potential for rapid change in status.
- Instilling acceptance of this practice (with both staff and patients) as a therapeutic and beneficial strategy for assisting the patient in terms of safety and potential for enhancement of rapport with care-givers. There is also increased opportunity to impart (and gather) further information about current sources of, eg stress/distress, and to give added support towards recovery in terms of therapeutic ‘hand-holding’ at times of increased vulnerability.
- Establishing systems for day-to-day management of patients assigned varying observation levels, including managing logistics of repetitive reviews.

Point of note:

In the absence of standardised validated risk assessment measures, examples of risk assessment tools with evaluative comments can be found in the Best Practice in Managing Risk. Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services (Scottish Risk Management Authority’s Risk Assessment Tools Evaluation Directory), and within the Standards for ICPs toolkit.
Section 3: Admission to hospital – exchange of information

Key points:

1 Admission to hospital is a potentially distressing (possibly even traumatic) experience for the patient, carer(s) and relevant others. All staff involved in the admission process should be aware of this potential and should therefore provide information and support for the patient, carer(s) and relevant others throughout the admission procedure and subsequent admission.

2 In order to provide accurate information on the patient’s and carer’s rights, mental health professionals require up-to-date knowledge of current mental health legislation and related issues.

3 Information provided to the patient should be given in a manner that reflects all care options, embraces the principles of recovery and conveys hope.

4 The first 72 hours are particularly important in an individual’s admission, requiring orientation, guidance, information, engagement and reassurance – all of which must be informed by the vulnerability, capacity and accessibility of the individual at that point.

5 Appropriate clinical guidelines (condition-specific) should be followed as advocated by Scottish Intercollegiate Guidelines Network (SIGN), The National Institute for Clinical Excellence (NICE) and the World Health Organisation (WHO), for example, those relating to admission with first episode psychosis.

6 Communication is a two-way process and patients, carer(s) and relevant others should be encouraged to ask questions, as much as possible, in order to strive towards establishing a ‘partnership’ in care, as far as possible.
**Statement 3(a)**  
Health professionals guide the patient, carers(s) and relevant others through the formalities of the admission procedure in an environment that is conducive to comfort and privacy\(^1\), ensuring that the process is clearly explained and understood, as far as can be achieved, whilst also ensuring that all relevant records are completed.

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<tr>
<td>The patient, carer(s) and relevant others require information on what is happening and what is likely to happen during the admission procedure and inpatient period(^1). Information should be given to the patient, carer(s) and relevant others, offering clarity about the reason for the admission. Information is more meaningful when tailored to the needs of the patient, carer(s) and relevant others. ‘Giving patients, carer(s) and relevant others information about the illness and available services/treatments has been shown to improve understanding. This helps maintain vital relationships and improve outcomes for the patient, carer(s) and relevant others in the longer term’(^3).</td>
<td>There is documented evidence that relevant information has been given to the patient, carers(s) and relevant others, where practical, including the following:  - advocacy service  - patient rights if subject to compulsion  - level of observation discussed and agreed with patient  - benefits, finance, accommodation  - chaplaincy services  - condition and presentation of symptoms  - current/ongoing assessment of risk  - effects and side effects of medication  - named nurse/key worker  - Mental Welfare Commission  - orientation to environment  - other disciplines involved in care, eg occupational therapy, psychology, psychiatry, social work, pharmacy, etc  - visiting hours  - ward routine such as mealtimes, medication, case reviews, etc  - ward/service philosophy - values-based, recovery-focused, etc, and  - complaints procedures.</td>
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**Key challenges:**
- Ensuring mechanisms for timely and appropriate transfer of information between services are established, utilised and supported.
- Ensuring that the ward is conducive to a therapeutic environment to meet the varied needs of individuals, often from a variety of social and cultural backgrounds.
- Balancing the requirements of providing interview rooms to the standards set by the Royal College of Psychiatry whilst ensuring comfort and privacy.
- Ensuring the purpose of passing information is to support and inform the person in their recovery and does not become merely a process of admission.
### Statement 3(b)

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<tr>
<td>The named nurse/key worker and their role should be clearly identified during the admission process. Communication between the named nurse/key worker and the patient, carer(s) and relevant others is key.</td>
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<tr>
<td>This assists in establishing a therapeutic relationship, rapport and trust between the patient, carer(s) and relevant others and health professional.</td>
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<tr>
<td>May enhance confidence of the patient, carer(s) and relevant others when communicating with health professionals, promoting consistency and continuity of care.</td>
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<tr>
<td>There is documented evidence that the patient, carer(s) and relevant others have been advised of their named nurse/key worker and their role.</td>
</tr>
<tr>
<td>There is a note of feedback given by patient, carer(s) and relevant others commenting on their satisfaction and confidence with the communication process established with the named nurse/key worker.</td>
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### Key challenge:

- Developing systems of work that support a sense of consistency/confidence for the patient, carer(s) and relevant others and promoting continuity of care provision.
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| Information is provided in a format/language that the patient understands and is reiterated where required throughout their stay. Equality and diversity impact is considered with regards to the giving of information. | It is incumbent on health services to be more diverse in their approach to mental health care with increased awareness of issues such as people’s abilities with regards to literacy, multi-cultural needs, language, etc. Health professionals must be aware of the potential for a patient, carer(s) and relevant others to lack ability to absorb information at times of distress and change. To comply with the requirements of the MH(S)A.
To comply with equality and diversity legislation and impact assessment requirements. | There is documented evidence of what information has been given to the patient, carer(s) and relevant others including:
- who provided the information and in what format, eg working with principles of cognitive remediation/rehabilitation – eg use of compensatory aids (eg pictures or diagrams, large print, frequent repetition of information)
- when the information was provided
- if interpreters were used, use of deaf aids, etc
- reaction and response to the giving of information is recorded, and
- what information has not been given, the rationale for this, as well as who has the responsibility to remedy this at a later date, supporting the notion of information being given in a phased manner.
Additional detail should be documented when information is provided for specific groups, for example, ethnic minorities or patient(s) with a sensory impairment, who may require use of specialist services. |

**Key challenges:**
- Ensuring that the provision of information to patients, carer(s) and relevant others, throughout the inpatient stay, is a recurring partnership process.
- Increase awareness of policy/legislation that may impact on the needs of individuals admitted to mental health services, eg Adults with Incapacity (Scotland) Act and Adult Support and Protection (Scotland) Act.
- Ensuring capacity of all staff (ie qualified and unqualified) to enable patients to check and ask questions – open, dynamic approach to communication.
- Enhancing understanding of cultural and religious factors that may impact on patient, carer(s) and relevant others understanding or experience of mental illness and acute services.
### Statement 3(d)

**Reason for statement**

Health professionals have enhanced skills post registration and/or developed competencies to assess and admit a patient to an inpatient setting and have the authority to do so.

**How to demonstrate statement is being achieved**

Multidisciplinary education is a strong underpinning element that supports the development of effective, capable teams, and the benefits of multidisciplinary education and training are well recognised.15

Examples of enhanced skills may include cognitive behaviour training, diagnostic and formulation skills, psychosocial intervention training, etc.

Evidence of enhanced training for health professionals is reflected in supervision/performance development review documentation.

This evidence will be aligned to key ministerial targets laid out by the Scottish Government Health Department, eg HEAT target - NHS boards to ensure that all employees covered by Agenda for Change (AFC) have an agreed Knowledge Services Framework (KSF) and personal development plan by March 2009.38

### Key challenges:

- Developing and sustaining systems of work that ensure appropriate ongoing training, development and support for health professionals.
- An example of specific training required is suicide prevention training (Commitment 720) - 50% of frontline staff in mental health and substance misuse services, primary care and A&E being educated and trained in using suicide tools/suicide prevention programmes by 2010-2013.20
### Statement 3(e)

All information with regard to a patient’s medication should be accessed to ensure the correct medications are being prescribed.

### Reason for statement

Accurate prescribing and effective exchange of medicines (prescribing of different medications when appropriate) is essential on admission.

Similar lines of communication are advocated pre-discharge to ensure continuity of care and promote concordance.

Involving professionals with specific specialist knowledge with regards to medications, eg consultant psychiatrist, other relevant medical staff, pharmacists, non-medical prescribers, etc, promotes access to high quality information which may assist the patient in making informed contribution to medication options/choices.

### How to demonstrate statement is being achieved

There is documented evidence of communication with specific sources, for example:
- consultant psychiatrist/depute
- GP
- community pharmacists
- community mental health teams, and
- acute hospitals.

Information on medications including effects and potential side effects is given to the patient in a format which they understand. This may include provision of written information leaflets that have been approved at local level.

The patient has been informed of their rights to information and how to access it regarding medications.

### Key challenge:

- Promoting and developing systems which ensure multidisciplinary involvement and utilisation of specialist knowledge within a culture of patient-focused partnership.
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<tr>
<td>Other agencies/services engaged with the patient should be informed of their admission status and invited to exchange any relevant information, eg voluntary and non-statutory agencies and social work departments.</td>
<td>Admission to inpatient services is seen as a transient phase in the recovery process. Good inter-agency communication helps facilitate smooth transition of care on discharge and promotes potential for ongoing contact with the patient, whilst an inpatient. Elements such as housing, benefits and other financial implications of admission to hospital must be carefully considered as early as possible on admission in order to allow a multi-agency approach to support the patient following discharge.</td>
<td>There is documented evidence of all communications with other agencies including: • who the communication involved • in what format • when the information was provided • what was the content and expectation as a result, and • what, if any, bearing did a specific communication have on the admission.</td>
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<td>All information being shared should be in accordance with local information-sharing protocols.</td>
<td>Supports the care programme approach (CPA) system of working (when appropriate).</td>
<td>Recording and sharing of information is a basic principle within standards 6 and 7 of the Standards for ICPs.</td>
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**Key challenges:**
- Ensuring engagement with services supports inter-speciality/agency working, eg addiction services, local authority, housing department, etc.
- Ensuring that mechanisms for timely and appropriate transfer of information between services are established, utilised and supported.
- Keeping the patient at the centre of this process as advocated in the Standards for ICPs with specific regard to integration.
Section 4: Assessment and planning for recovery

Key points:

1. Assessment and planning for recovery should be a partnership between the patient, carer(s) and relevant others, health professionals and other relevant disciplines/agencies.

2. All health professionals will support patients to plan their recovery journey using person-centred assessment and care planning approaches.

3. Development of any plan for recovery should reflect a patient’s past and current wishes with consideration being given to any advance statement, wellness recovery action plans or crisis care plans that may exist.

4. ‘The specific outcome measures to be used by particular services or clinicians will be dependant on the purpose for which they are required. Outcome measures are not an end in themselves, but a tool to enable clinicians and others to reflect on their work and to facilitate the improvement of the services provided to users.’

Health professionals carry out an assessment of need by means of a combination of clinical interview that is person-centred, recovery focused, and uses standardised assessment tools and outcome measures, eg Camberwell Assessment of Need, HoNOS, FACE, CORE, BPRS, and AVON (see Glossary for definitions).

**Statement 4(a)**

An accurate assessment of need provides a basis for planning care and can facilitate a person-centred approach as advocated within standard 16 of the Standards for ICPs.

The use of structured standardised screening tools can improve assessment and give an indication as to what interventions may be beneficial.

Outcome measures in acute mental health allow the efficacy of treatment to be measured.

Assessment tools may indicate the need for additional screening, eg for alcohol or illicit substances.

Outcome measures provide clinicians with information useful for the development of evidence-based clinical practice and enable them to 'build up a picture of the effectiveness of various therapeutic approaches'.

Outcome measures should be informative and be cross-referenced to HEAT targets.

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Outcome measures should be informative and be cross-referenced to HEAT targets.

**How to demonstrate statement is being achieved**

There is documented evidence of:

- the needs identified from assessment
- patient, carer(s) and relevant others perceptions and reaction to/participation in identified needs
- initial recovery care plan developed by identifying and agreeing strengths with the patient, carer(s) and relevant others
- planned reviews with the patient, carer(s) and relevant others and documentation to this effect being provided
- specific information provided relating to pharmacological treatments
- assessment of occupational function including engagement in self-care, productivity (work, employment) and leisure tasks
- assessment outcome measures used
- recovery care plans written in a person-centred language – ‘plain English’
- equality and diversity issues considered when developing the recovery care plan
- patient entry to notes - patient should have the opportunity to write in their own records (when appropriate and with agreement from the RMO)
- patient, when appropriate, has opportunity to sign off when recovery goal met, and
- written and verbal communications with the patient, carer(s) and relevant others educating them as to what is meant by recovery and their response/interpretation.

**Key challenges:**

- Encapsulating a person-centered assessment.
- Identifying and dealing with specific vulnerabilities, eg adolescents, ethnic minorities, patients with disabilities, learning difficulties, difficulties with literacy and/or understanding and single sex environments.
- Increasing awareness of the impact of cultural and spiritual/religious factors on assessment and recovery planning.
- Achieving service design that is needs-led and person-centered.
- Ensuring all relevant persons attend recovery-based training, eg 10 Essential Shared Capabilities for Mental Health Practice: Learning Material (Scotland) (ESCs).
- Consideration and development of electronic-based recording systems which promote single site documentation for all disciplines, eg FACE as used in NHS Ayrshire & Arran (see Glossary). This concept is supported in Better eHealth: Better Care and advocates we should 'build the platform for an electronic patient record that, in due course, will support patients' journeys through the NHS and support patient needs.'
- Incorporating data from outcome measures to inform service design/efficacy and relate to HEAT targets, eg the target set for reducing the number of re-admissions (within one year) for those who had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009 will be supported by the Acute Inpatient Forum work on admission and discharge. Such data should also inform the Scottish Recovery Indicators (SRI) process.
### Statement 4(b)

When relevant and appropriate, it is imperative that care managers/social workers and relevant others are informed and involved and given access early. Ensure the RMO is informed, on a regular basis, of all those involved in assessment and care.

### Reason for statement

Assessment of need should incorporate social needs as well as care needs, recognising there may be overlap of the two.

Effective recovery plans will reflect a multidisciplinary and multi-agency approach.

Promotes multidisciplinary and multi-agency involvement in review at regular intervals during admission and prior to discharge.

Promotes collaborative working and may help promote improved patient experience by sharing of information.

### How to demonstrate statement is being achieved

There is documented evidence of:

- consent to inform and involve other agencies
- content of communication, specifying who was involved
- outcome of communication
- how and what feedback is given to the patient, carer(s) and relevant others
- the timescale of feedback given, and noted in context
- any planned further action or communication
- detail of information given to the RMO including how and when communicated, and
- if communication is made without consent, rationale for same is clearly stated, including the RMO agreement/instruction.

### Key challenges:

- Ensuring systems are developed to encourage multidisciplinary and multi-agency working.
- Ensuring continued involvement of community mental health teams, crisis resolution teams and intensive community support services, social work and other agencies to support the process of early facilitated discharge, ideally planning from point of admission.
- Ensuring systems and staff competences/skills meet the needs to support the patient, carer(s) and relevant others when involving other agencies without consent, for example, in the event of a person being subject to compulsion or when adult/child protection issues arise.
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| Recovery plans should be developed in partnership with the patient, carer(s) and relevant others and with health professionals to ensure shared understanding of identified needs, the patient’s specific goals and proposed/planned interventions/strategies. | Planning care in partnership promotes shared understanding of recovery-focused interventions. Practices which reflect ownership of experience and contribution from the patient, carer(s) and relevant others in their journey of recovery. Supports systems of working which are aligned to local and national practice guidance such as the Standards for ICPs. | There is documented evidence of a plan of care which includes:  
- identified needs and strengths  
- patient-focused goals which are recovery-based, and  
- specific interventions highlighting:  
  - who is responsible for intervention including the patient’s own responsibilities  
  - how interventions are to be carried out/supported  
  - how interventions are to be evaluated in relation to journey of recovery and goals being achieved  
  - what consent has been sought and agreed  
  - who will review and in what timeframes  
  - RMO’s comments, guidance or instruction in relation to specific goals, and  
  - record of disagreement of proposed interventions and goals between patient and health professionals. |
| Review is ongoing and part of multidisciplinary team meetings including involvement of relevant others from outwith the ward setting, e.g. GP, primary care clinicians including community-based key worker. | The process of review ensures a range of interventions are explored and utilised, recognising the dynamic nature of assessment and recovery plans and should involve the patient, carer(s) and relevant others as much as possible. | |

**Key challenge:**

- Adopting a culture of inclusion where healthcare professionals in the primary care setting, community-based services and GPs are viewed as being integral to inpatient care and contribute to the development of recovery plans.
Section 5: Holistic assessment of psychosocial, occupational and physical needs and strengths

Key points:

Although identified within this specific section, the factors below are key to assessment of an individual’s mental health and allow important access to contributory factors affecting deterioration in mental state and requirements for intervention and recovery. They must not be viewed as an additional aspect or ‘add on’ to traditional medical/symptom-focused assessment and should be considered as an integral component in all aspects of the patient experience.

1 Structured psychological and/or psychosocial interventions can benefit patients, carer(s) and relevant others, either as the primary means of treatment or in addition to other treatments. This is reflected further when identifying condition-specific guidelines, for example, relating to schizophrenia, bipolar disorder, personality disorder, etc. Interventions include family therapy and cognitive behaviour therapy.

2 Effectiveness is based upon the person delivering the training (trained and accredited) and practising within a framework of supervision, support, audit and review.

3 Clinical psychology services and other disciplines trained in the use and application of psychological theories and interventions (for example, some psychiatrists, psychotherapists, clinical nurse specialists, allied health professionals) ‘aim to enable other service providers to develop psychologically-informed ways of thinking; to use psychological knowledge to enhance and develop their professional practice to the benefit of their clients; to be able to enhance their sense of self-understanding, self-respect and self-worth; and to use psychological data to aid decision-making at a clinical, organisational and societal level.’

4 Patients, carer(s) and families must be given support when learning of the importance of maintaining and improving their physical health and the beneficial effects on mental health. Information must be provided in accessible formats to help illustrate ways to reduce possible risks to health.

5 Prevention of admission may be achieved by interventions being available within primary care. Information and guidance is available on The Matched/Stepped-Care Model and Psychological Therapies, a strategy for best meeting the demands on a service. ‘If providing treatment to any patient population presenting with problems spanning a spectrum of severity, evidence suggests that a matched/stepped care model is the best way to make use of limited resources.’

6 Health promotion and prevention actions should be given consideration ‘drawing on promising evidence, for example, around community referral of social prescribing.’
### Statement 5(a)

**Reason for statement**

Health professionals in relevant disciplines working in partnership with the patient, carers(s) and relevant others are involved in assessing the patient’s holistic needs and identifying their strengths while recognising that psychological assessment during this process is key. Carers(s) and relevant others needs should also be considered at this time and formally assessed when appropriate to do so.

Assessment should be ongoing and supported by RMO review.

**How to demonstrate statement is being achieved**

The importance of holistic assessment must be stressed within the context of multidisciplinary collaborative working which benefits patients.

The evidence base to support the use of psychological approaches to care is increasing, as is the professional base capable of providing this service. Multi-professional working facilitates the provision of psycho-educational/psychological approaches to care for the patient, carers(s) and relevant others.

It is beneficial for health professionals to be informed about relevant information and support services and be knowledgeable about how to sign-post them and methods of referral.

To adhere to principles of the MH(S)A.

Identifies when there is a need to endorse a care programme approach for those with identified complex needs.

There is documented evidence:

- of multiprofessional, psychological-based assessment and care planning including risk assessment
- that the plan reflects/addresses needs and strengths identified in earlier assessment
- of outcomes and recommendations from multidisciplinary review
- that all needs have been identified
- that there is a record that the patient and carer(s) have been offered a range of relevant therapies when/where available. This should include occupational intervention, for example, self-care, productivity and leisure, educational and lifestyle advice as well as psychological and/or psychosocial therapies
- of who will provide relevant therapies, eg psychologists, allied health professionals or nurses, with appropriate accredited training
- of target time within which holistic assessment will be completed (as may take several interactions to gather information), and
- of any consideration and action proposed to using the care programme approach.

### Key challenges:

- Ensuring that treatment offered will be evidence-based, effective, efficient and delivered to the highest possible standards within sustainable systems and that the journey of care will be smooth and quick, providing patients with the treatment they need, at the level they need it, where they need it and when they need it.

- Ensuring that systems of supervision and evaluation are developed and used routinely when supporting staff in all aspects of their work. This will include provision of education, training, support and clinical supervision for all relevant staff to enable their involvement in assessment, delivery and evaluation of psychological and psychosocial interventions and to support pursuance of accreditation.

- Embedding this form of support and development in the culture of the organisation. The structuring of this necessity requires to be considered.

- Ensuring there is good access to the service through well-defined care pathways to psychological therapy as advocated in standard 15 of the Standards for ICPs.

- Ensuring appropriate levels of health professionals accredited in psychological and psychosocial therapies are funded and made available to inpatient sites.

- Practical consideration to how therapy/intervention may continue and transfer to alternative care setting, ie on discharge from hospital with community-based follow-up.
## Statement 5(b)

| Physical needs and their potential impact on mental health and wellbeing are assessed by medical staff and other relevant health professionals who have the appropriate knowledge and skill base. This should include, for all persons admitted, baseline investigations involving urinalysis, blood pressure and pulse, urinary drug screen, full blood count, urea and electrolytes, blood glucose and other basic biochemistry as required. Attention should also be given to evidence of physical trauma, concurrent physical illness, etc. |

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<td>A holistic approach to care includes the physical and mental health of a person, as well as their knowledge and skills.</td>
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<td>To ensure appropriate follow-up is arranged when required.</td>
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<tr>
<td>To ensure that key elements such as engagement (between health professionals and patient), health assessment, care and support are progressed.</td>
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<tr>
<td>To illicit and record possible differential diagnosis and any concurrent physical illness.</td>
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<tr>
<td>May facilitate opportunity to discuss/address issues on physical care and wellbeing.</td>
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| The mortality rate from physical illness for those with mental health problems is significantly higher than in the general population.

## How to demonstrate statement is being achieved

- There is documented evidence of physical assessment including:
  - who is involved in the assessment
  - their identified discipline, eg dietetics, physiotherapy, podiatry, occupational therapy, nursing
  - findings from assessment with recommendations for further action where appropriate
  - communication with the RMO including indicated instructions
  - if no communication with the RMO then state rationale
  - communication to other appropriate health professionals including specialists, when required
  - any subsequent interventions or plans for further/specialist investigation
  - what information has been discussed with the patient and how information has been given, and
  - that appropriate chaperoning of health professionals during physical assessments and/or other interactions was given, including name of chaperone.

## Key challenges:

- Ensuring that local systems of care management indicate responsibilities of individual clinicians and teams with regard to facilitating health screening.
- Ensuring co-ordination of any required physical health re-assessments/interventions as an ongoing aspect of care in promoting recovery.
- Ensuring a culture of multidisciplinary inclusion in all aspects of the patient experience is developed and nurtured.
Section 6: Planning recovery and working towards discharge

Key points:

1. Planning recovery and working towards discharge is a partnership between the patient, carer(s) and relevant others and healthcare providers and should begin as early as possible in the episode of care.

2. Discharge planning requires dedicated time from the patient, carer(s) and relevant others involved in care to discuss, agree and facilitate support required, making the transition from inpatient care back to the community as smooth as possible for all patients.

3. Community mental health teams and/or primary care teams play a core role in support on discharge, and information on inpatient episode of care, progress to date and current risk assessment and management plan should be available to all persons/agencies involved in the discharge process.

4. ‘The discharge of the patient is planned prior to discharge and all relevant information should be communicated at the appropriate time to the patient and to those involved in continuing provision of care’. This should include informal carer(s).

5. A ‘whole systems’ philosophy to care promotes improved levels of discharge planning across all demographic variables.
**Statement 6(a)**

Health professionals, in collaboration with other relevant disciplines and agencies, the patient, carer(s) and relevant others should determine the level of support required for the transition from inpatient episode to the community. All potential therapies and interventions to support and further aid recovery on discharge should be identified and discussed fully with the patient, carer(s) and relevant others, prior to discharge.

This will initiate an interim discharge care plan, prior to discharge, which should be facilitated through multidisciplinary pre-discharge meetings.

**Reason for statement**

Discharge planning should be gradual, well-planned and managed as a partnership process which is reviewed regularly throughout an inpatient stay and viewed as an integral aspect of the recovery process.

Effective discharge planning begins on, or shortly after, admission and is a continual process. Communication and transfer of information among health professionals and all relevant agencies involving the patient, carer(s) and relevant others throughout are essential in ensuring a seamless process\(^\text{18}\). Discharges and/or transfers are planned in partnership with the patient, carer(s) and relevant others including external agencies, as required, address the need for aids, adaptations and support, and ensure that arrangements are in place to meet these needs, where possible\(^\text{19}\).

**How to demonstrate statement is being achieved**

There is documented evidence that:

- discharge planning is ongoing and recovery focused
- each review of the discharge plan is documented including the identification of further planned review dates and detail that this has been communicated to the patient, carer(s) and relevant others
- robust policy and procedures ensure alignment of common goals between inpatient and community-based care provision, eg local discharge protocols
- there have been considerations, referral to, and participation in, activities that potentially aid recovery such as ‘staying well groups’, relapse prevention education, promoting the management of medication, etc, and
- information has been provided on whom to contact should difficulties arise or with any queries.

**Key challenges:**

- Developing practice that ensures when a person has a diagnosis of schizophrenia, bipolar disorder, dementia, depression or borderline personality disorder, care provision should be aligned to guidance found in the Standards for ICPs\(^\text{4}\). The document also provides guidance on generic care standards.
- Ensuring planned pre-discharge meetings are communicated to all relevant persons, with advance notice, promoting attendance.
- Systems are in place to ensure requirements for follow-up are communicated following a quick discharge. For example, if the patient is discharged as a result of breach of inpatient agreement/contract, taking discharge against medical advice, rapid recovery and insistence of discharge.
- To ensure staff refer to and adhere to local protocols or establish new protocols as necessary.
### Statement 6(b)

At point of discharge, all appropriate services are in place to support the patient, carer(s) and relevant others, and all relevant information including individual recovery and ‘staying well’ care plans has been conveyed to appropriate others.

### Reason for statement

‘Discharge and/or transfer plans need to be well co-ordinated and based on a patient’s assessed needs. This can only be achieved through planning and communication’4.

‘The discharge and transfer of care of people from one setting to another is one area where continuity of care can breakdown especially if inadequate information is transferred’4.

### How to demonstrate statement is being achieved

There is documented evidence that:

- all communications with the patient, carer(s) and relevant others including health professionals and other agencies are recorded
- patient and carer(s) have an interim point of contact after discharge but before planned follow-up contact begins
- a care plan is in place with explicit detail about follow-up arrangements, eg when, where and who will be involved, and
- the care plan is written in a format that the patient, carer(s) and relevant others understand.

### Key challenges:

- Where follow-up is advised, patient(s) are seen by the appropriate service/agency/health professional. The timeframe for follow-up appointment may range from the day after discharge to within one week depending on assessed and agreed need as advocated in Delivering for Mental Health National Standards for Crisis Services24,56.
- Ensuring timely implementation of a robust plan of care when a patient discharges themselves against medical advice.
- Supporting community mental health teams to have continued contact with the patient, whilst an inpatient, in order to facilitate a seamless transition of care.
Statement 6(c) | Reason for statement | How to demonstrate statement is being achieved
--- | --- | ---
Discharge planning incorporates current/ongoing risk assessment and management plans and should reflect the move to community. | Risk assessment enables the initiation and maintenance of appropriate risk management strategies. | There is documented evidence that:
- ongoing risk assessment and management have been included in the discharge plan. This should include, for example, early warning signs, relapse indicators and potential actions to be taken in the event of potential relapse, and
- the patient has been involved (as far as possible) in compiling the care plan and that it should include details of how/where they and their carer(s) can access help both in and out of hospital system (e.g., named nurse, key worker, community psychiatric nurse details, etc.).

Key challenge:
- When deemed necessary, agreeing a plan of care within a care programme approach framework involving the patient, carer(s) and relevant others together with all health professionals and relevant care providers. Communicating specific roles and responsibilities prior to discharge.
<table>
<thead>
<tr>
<th>Statement 6(d)</th>
<th>Reason for statement</th>
<th>How to demonstrate statement is being achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients that require follow-up at point of discharge should have a plan of care in place and documented appropriately.</td>
<td>If a person is being discharged from an inpatient setting to the community under the MH(S)A, a care plan ‘must’ be formulated prior to discharge to comply with the Act. Continuity of care is promoted, facilitating a seamless service, improving patient experience.</td>
<td>Recorded evidence that a plan of care is in existence and that the patient, carer(s) and relevant others have been given a copy.</td>
</tr>
</tbody>
</table>

**Key challenge:**
- Applying the principles of discharge planning when a patient experiences suspension of detention, is on arranged pass or leave of absence, including risk assessment and management plan.
### Statement 6(e)

**Reason for statement**

Health professionals and pharmacists in partnership with the patient, carer(s) and relevant others assess the ability of the patient to self-manage medication and their need for support post-discharge. This will include the ability to order repeat prescriptions, understand the importance of monitoring and what to do if they encounter a problem. Follow-up plans and requirements are communicated to community pharmacists and the GP.

**How to demonstrate statement is being achieved**

There is benefit from ensuring community supports are in place to support concordance especially if compliance aids are to be dispensed by community pharmacists. This will involve effective assessment of needs and appropriate communication to community pharmacy and GP, reducing the risk of re-admission.

There is documented evidence of:
- what assessment has taken place
- who carried out the assessment
- outcomes of assessment with recommended actions
- what information has been given to the patient, carer(s) and relevant others and in what format
- what information, expectations and requirements of other service providers has been agreed, and
- follow-up arrangements such as monitoring requirements, consultant review appointment, medication information and patient responsibilities.

### Key challenges:

- Ensuring systems are in place to provide appropriate and timely communication with community pharmacists.
- ‘Details about and arrangements for transport, provision of medication, emergency contact arrangements and final notification to community services need to be communicated to professional staff, service users and carer(s)’[39].
### Statement 6(f)

<table>
<thead>
<tr>
<th>Reason for statement</th>
<th>How to demonstrate statement is being achieved</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The need for long-term monitoring and management of physical parameters (eg weight, lipids, glucose, etc) for patients on, for example antipsychotic medication, must be identified and communicated to appropriate community resources, eg GP, community mental health team, dieticians, etc.</td>
<td>There is documented evidence: • of who has been informed of requirements for monitoring and by whom • of who will carry out monitoring and what this will consist of, how it will be recorded, etc, and • that the patient, carer(s) and relevant others have been involved in discussion regarding monitoring, its nature and importance, including explanation of why any agreed aspect of self-monitoring, including what to report, when and to whom.</td>
<td></td>
</tr>
<tr>
<td>Ensuring that monitoring requirements are communicated in an appropriate and timely manner improves engagement between the patient and health professionals, promotes health and informs early detection of changes in physical/mental health. This further gives indication of potential actions required to manage physical health needs as per generic standard 13 (section 2.2) within the Standards for ICPs.</td>
<td></td>
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</tbody>
</table>

#### Key challenge:
- Developing a culture where mental health service providers acknowledge and recognise the importance, significance and relationship of physical health in relation to mental health and developing services to enhance holistic health and patient experience.
Appendix 1: Audit tool

This audit tool has been developed from the Best Practice Statement for Admissions to Adult Mental Health Inpatient Services (March 2009) to support health professionals and organisations who would like to audit current local practice. This should be used in conjunction with the best practice statement and not in isolation.

<table>
<thead>
<tr>
<th>Section 1: Pre-admission/initial assessment of need</th>
<th>Y</th>
<th>N</th>
<th>Don’t know</th>
<th>Action and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Initial assessment of need by means of clinical interview has been undertaken</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b Assessment was multidisciplinary in nature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c All available information was sought and considered at time of assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d All options including inpatient admission and use of community-based care were considered, explored and discussed with the patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e Purpose for and benefits from admission have been identified, or potential benefits if choosing alternatives to admission</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>f Ascertain if an advance statement, single shared assessment or other action plan exists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g Consideration has been given to RMO’s existing management plans (where relevant)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h Needs of carer(s) and relevant others have been assessed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i All relevant documentation has been completed timeously</td>
<td></td>
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</tbody>
</table>
## Section 2: Risk assessment and management

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>Don’t know</th>
<th>Action and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
<td></td>
<td>Initial risk assessment has been carried out through clinical interview and use of risk assessment tools</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td>Information from other relevant sources has been sought and considered, for example, community mental health teams, general practitioner</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
<td></td>
<td>A risk assessment and management plan has been formulated</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td></td>
<td></td>
<td>The patient's strengths and personal perception of recovery have been identified and reflected in the risk management plan</td>
</tr>
<tr>
<td>e</td>
<td></td>
<td></td>
<td></td>
<td>The RMO has been contacted and consulted</td>
</tr>
<tr>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td>The patient was involved in the formulation of a risk management plan</td>
</tr>
<tr>
<td>g</td>
<td></td>
<td></td>
<td></td>
<td>Levels of observations have been identified and discussed with patient, carer(s) and relevant others</td>
</tr>
<tr>
<td>h</td>
<td></td>
<td></td>
<td></td>
<td>Detail of risk assessment and management plan has been communicated to all members of the care team</td>
</tr>
<tr>
<td>i</td>
<td></td>
<td></td>
<td></td>
<td>A copy of the risk assessment and management plan has been given to the patient</td>
</tr>
</tbody>
</table>
## Section 3: Admission to hospital – exchange of information

<table>
<thead>
<tr>
<th></th>
<th>Information regarding the admission process has been given to the patient</th>
<th>Y</th>
<th>N</th>
<th>Don’t know</th>
<th>Action and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>The named nurse/key worker and their role has been clearly identified during the admission process</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>b</td>
<td>The language and format that information has been provided in has been reported to be appropriate by the patient</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>c</td>
<td>Information not given to the patient and the reasons for this have been appropriately recorded</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>d</td>
<td>The patient has been shown around the ward</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>e</td>
<td>Information regarding the individual’s medication has been collated from all relevant sources, considered and recorded</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>f</td>
<td>Other agencies/services engaged with the patient have been informed of the admission status and invited to exchange any relevant information</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
</tr>
<tr>
<td>Section 4: Assessment and planning for recovery</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>a An assessment of need by means of a clinical interview has been carried out</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b A standardised assessment tool has been used to support the assessment</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>c (When relevant and appropriate) care managers/social workers and relevant others have been informed of the patient’s admission</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>d Recovery care plans have been developed in partnership with the patient</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>e Recovery care plans reflect the patient’s past and current wishes with consideration being given to any advance statement, wellness recovery action plans or crisis care plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f The patient has had an opportunity to make entry into their own documentation</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>g A multidisciplinary review date/schedule has been agreed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 5: Holistic assessment of psychosocial, occupational and physical needs and strengths</td>
<td>Y</td>
<td>N</td>
<td>Don’t know</td>
<td>Action and comments</td>
<td></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>a</td>
<td>A psychological-based assessment of the patient has taken place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>A psychological-based assessment was multidisciplinary in nature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>A psychological-based assessment has been offered to carer(s) and relevant others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>A range of therapies have been discussed with the patient following assessment of needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Carer(s) and relevant others have been informed of all available relevant therapies/interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Physical needs and their potential impact on mental health and wellbeing have been assessed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Physical baseline investigations have been carried out and appropriately recorded</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>h</td>
<td>Communication to other appropriate health professionals, including specialists, when required, have been recorded</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section 6: Planning recovery and working towards discharge**

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>Don’t know</th>
<th>Action and comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td></td>
<td></td>
<td></td>
<td>The level of support required for the transition from inpatient episode to the community has been identified</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td>Potential therapies and interventions to support and further aid recovery on discharge have been identified and discussed fully with the patient prior to discharge</td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
<td></td>
<td>An interim discharge recovery care plan, ‘prior’ to discharge, has been developed in collaboration with the patient, carer(s) and relevant others</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td></td>
<td></td>
<td>There has been consideration and referral to organisations/activities that potentially aid recovery such as staying well groups, relapse prevention education programmes</td>
</tr>
<tr>
<td>e</td>
<td></td>
<td></td>
<td></td>
<td>Information has been given regarding who to contact should difficulties arise or with any queries</td>
</tr>
<tr>
<td>f</td>
<td></td>
<td></td>
<td></td>
<td>Explicit detail about follow-up arrangements, for example, when, where and who will be involved was given prior to discharge</td>
</tr>
<tr>
<td>g</td>
<td></td>
<td></td>
<td></td>
<td>At point of discharge, all appropriate services were in place to support the patient, carer(s) and relevant others</td>
</tr>
<tr>
<td>h</td>
<td></td>
<td></td>
<td></td>
<td>Relevant information, including individual recovery and ‘staying well’ plans of care, has been conveyed to appropriate others</td>
</tr>
</tbody>
</table>

Please see the NHS Quality Improvement Scotland website (www.nhshealthquality.org) to download a Word version of this audit tool to save and use electronically, or print to use by hand.
Appendix 2: Millan Principles

**Non-discrimination** - People with mental disorder should, wherever possible, keep the same rights and entitlements as those with other health needs.

**Equality** - All powers under the Act should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.

**Respect for diversity** - Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds.

**Reciprocity** - Where an obligation is imposed on an individual to comply with a programme of treatment of care, an obligation is also imposed on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion.

**Informal care** - Wherever possible, care, treatment and support should be provided to people with mental disorder without the use of compulsory powers.

**Participation** - Service users should be fully involved, so far as they are able to be, in all aspects of their assessment, care, treatment and support. Their past and present wishes should be taken into account. They should be provided with all the information and support necessary to enable them to participate fully.

**Respect for carers** - Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

**Least restrictive alternative** - Service users should be provided with any necessary care, treatment and support both in the least invasive and least restrictive way, and in a place that allows the delivery of safe and effective care, taking into account the safety of others, where appropriate.

**Benefit** - Any intervention under the Act should be likely to produce a benefit for the service user.

**Child welfare** - The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act.
Glossary

Acute Inpatient Forum
The membership of the Acute Inpatient Forum is representative of key clinicians involved in delivering acute inpatient care, local authority partners, voluntary organisations and service users and carer(s). There is a minimum of one forum for each NHS board area.

advance statement
Section 275 of the Mental Health (Care and Treatment) (Scotland) Act 2003 allows a person to make an advance statement. It is a written statement setting out how a person would wish to be treated for a mental disorder.

advocacy service
An individual (paid or voluntary) who acts independently on behalf of, and in the interests of, patients/carer(s) who may feel unable to represent themselves in their contact with a healthcare or other facility. Advocacy is when support and representation is provided independently from those providing care, to minimise conflicts of interest and to assist an individual to express their views/wishes when they feel particularly vulnerable and disempowered. An advocate may not be a legally qualified person, but may be trained and supported by an advocacy project/service.

AVON
Avon Mental Health Measure: a user-centred approach to assessing need.

Brief Psychiatric Rating Scale (BPRS)
Rating scale used to assess presence and severity of symptoms of mental illhealth using a 24 symptom construct, each rated in a 7-point scale of severity.

Camberwell Assessment of Need
The Camberwell Assessment of Need (CAN) is an assessment measure, which assesses the health and social needs of people with mental health problems.

integrated care pathway (ICP)
A multidisciplinary outline of anticipated care, associated with a predicted timeframe, to assist a patient with specific condition or set of symptoms, to positively progress in recovery.

care programme approach (CPA)
A process which aims to ensure that people with severe and enduring mental illness (such as schizophrenia), who also have complex social care needs, are provided with coordinated care and supervision.

CRAG
Clinical Resource and Audit Group. Now part of NHS QIS.

cognitive behaviour therapy
See psychosocial interventions.

community mental health team (CMHT)
A group of professionals from a variety of different disciplines (eg medical, nursing, occupational therapy, social work) who work together to provide a range of mental health services outwith the hospital setting.

co-morbidity
The co-existence of more than a single mental disorder, eg anxiety and depression, schizophrenia and addiction. May also relate to the co-existence of physical health problems that may exacerbate mental health problems or may be exacerbated by mental health problems.

Clinical Outcomes in Routine Evaluation (CORE)
The CORE (Clinical Outcomes in Routine Evaluation) system is a system of measures/instruments, and crucially a philosophy and set of tools, to help people use these to monitor routine outcome in psychological therapies.

crisis care plan
A plan for recovery developed in partnership with the patient, carer(s) and relevant others used to give recognition and planned response to symptoms of relapse.
critical incident review
Multidisciplinary analysis and review of management of critical incidents as a form of learning tool.

Clinical Standards Board for Scotland (CSBS)
Clinical Standards Board for Scotland. Now part of NHS QIS.

discharge planning
Gradual process of assessing the level of support in order to make the transition from inpatient care to community care.

DoH
Department of Health

equality and diversity
A response to the Race Relations Amendment Act. The Act requires NHS boards to assess their functions for relevance to race equality. However, the Scottish Government Health Directorate equality and diversity impact assessment toolkit includes all six equality strands and other crosscutting ones to ensure that all policy and service development within NHSScotland can be shown not to disadvantage any individuals because of their age, ethnicity, gender, religion or faith, disability or sexual orientation.

functional analysis of care environments (FACE)
Electronic record-keeping system.

functional skills
Physical abilities to function, eg bathing, mobility, communicate.

HEAT target
Health Improvement, Efficiency & Governance, Access to Services, and Treatment. HEAT targets are a core set of Ministerial objectives, targets and measures for the NHSScotland.

HoNOS
Health of the Nation Outcome Scales: The Royal College of Psychiatrists’ Research Unit developed scales to measure the health and social functioning of people with severe mental illness. The initial aim was to provide a means of recording progress towards the Health of the Nation target to improve significantly the health and social functioning of mentally ill people.

home treatment teams/intensive community support services
Teams of health professionals, often multidisciplinary, with a dedicated remit to provide rapid response and intensive support to those in mental health crisis.

key worker
Nurse identified as responsible for the nursing assessment, implementation and care planning during inpatient stay.

liaison nurse
Nurse who provides a means of communication between different groups or units within an organisation, eg psychiatry and A&E, primary care and secondary care.

Mental Health Collaborative
The Collaborative supports NHS boards to make the improvements needed to deliver against key national targets set out by the Scottish Government.

named nurse
Key person within the ward allocated to co-ordinate care of a patient and identified as a specific contact for the patient to liaise with. (This role may be adopted by an alternative discipline to a nurse.)

NICE
National Institute for Health and Clinical Excellence
observation
A process that ensures close monitoring of, and engagement with, someone who needs (for a period of time) intensive care and support. It is a formal structured process and, therefore, is fundamentally different from the normal monitoring of patients within a ward or care setting.

occupational need
Related to employment or role as reflected in Program Redesign Based on the Model of Human Occupation38.

outcome measure
A measure of the effects, beneficial or adverse, which a person experiences as a result of the care, treatments or services they have received.

patient-centred
The underpinning philosophy that the patient is placed at the centre of all aspects of care and that their views and experience of recovery are considered.

psychosocial interventions
(Psycho) education programmes: directed at patients or carer(s)/family members and have several aims. Improvement in knowledge of illness, its course and in compliance with treatment has been shown. There is also evidence of greater satisfaction with services provided. Some programmes go beyond the provision of information and take an educational approach to skills training or problem solving.

Family interventions: the aims of family interventions include reduction of frequency of relapse into illness and reduction of hospital admissions, reduction in the burden of care on families and carer(s), and improvement in compliance with medication.

Cognitive behavioural therapies: a collection of therapeutic approaches carried out with the aim of changing behaviour and altering thought patterns. The therapist helps the person to identify their own false or destructive beliefs in order to reduce distress and develop coping strategies.

risk assessment
Comprehensive assessment of the presence of risk factors both current and historical to determine current levels of risk to self and others.

risk management
A systematic approach to the management of risk, eg to reduce loss of life, financial loss, loss of staff availability, staff and patient/client/user safety, loss of availability of buildings or equipment, or loss of reputation.

Scottish recovery indicator (SRI)
The SRI is a method of assessing the extent to which practice in mental health services is focused around factors which are known to promote recovery.

senior charge nurse review
A process of review contributing to development of a core set of clinical quality indicators (CQIs) for nursing and midwifery.

standards for integrated care pathways (ICPs)
“An ICP determines locally agreed multidisciplinary practice, based on guidelines and evidence, where available, for a specific patient/client group. It forms all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement.” Definition by National Pathways Association, 1998.

therapeutic engagement
Observation where consideration is given to the use of activity, discussion and distraction processes, but with recognition of the need for silence and as much privacy as achievable.

WRAP
Wellness and recovery action plan
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Who was involved in developing the statement

Project Manager

David Thomson
Mental Health Project Manager, NHS Quality Improvement Scotland

Working Group

Tom Allan
Clinical Area Manager
NHS Highland

Lesley Brady
Patient Services Manager
NHS Ayrshire & Arran

Margaret Christie
Commission Office
Mental Health Welfare Commission for Scotland

Isabel Easson
Clinical Governance Manager
NHS Fife

Frank Fallan
Public Partner, NHS QIS
Service User Representative,
Chair Person of NHS Lanarkshire Links
Mental Health Service User/Carer(s)
Involvement Project

Carol Gortmans
Public Partner,
NHS Quality Improvement Scotland
Vice Chair of National Schizophrenia Fellowship (Scotland),
General Member for Mental Health Tribunal

Hugh Hill
Director of Services
Scottish Association for Mental Health

Alison McDonald
Superintendent Physiotherapist
NHS Ayrshire & Arran

Ian McIntyre
Patient Services Manager,
Mental Health Service
NHS Dumfries & Galloway

Lorna Martin
Chief Nurse
NHS Lothian

Hazel Mitchell
Programme Director
Mental Health Services, NHS Tayside

Ruta Nicol
Senior Clinical Pharmacist,
Royal Edinburgh Hospital, NHS Lothian

Lorraine Robertson
Clinical Nurse Manager
Acute Mental Health Services,
NHS Forth Valley

Esther Stewart
Senior Occupational Therapist
NHS Lanarkshire

Susan Tennyson
Commissioning Nurse
Royal Edinburgh Hospital, NHS Lothian

Andy Wills
Service Manager
Royal Edinburgh Hospital, NHS Lothian

Alison Wilson
Psychiatric Assessment Team Co-ordinator
NHS Lanarkshire
Reference Group

Dr Keith Brown  Consultant Psychiatrist
              NHS Forth Valley
Patricia Cawthorne  Psychological Therapies Service Manager,
                    Clinical Nurse Specialist
                    The State Hospital
William Ellis  Scottish Recovery Indicator Lead
              Scottish Recovery Network
Beverley Grantham  Head Occupational Therapist
                    NHS Greater Glasgow and Clyde
Linda McKechnie  Service Development Manager (Mental Health)/National ICP Co-ordinator
                    NHS Quality Improvement Scotland
Kevin Milton  Senior Charge Nurse &
              Cognitive Behaviour Therapist
              NHS Ayrshire and Arran
Dr Katherine Morrison  General Medical Practitioner
                         Ballochmyle Medical Group, East Ayrshire
Dr Nabila Muzaffar  Consultant Psychiatrist
                    NHS Forth Valley
Alison Toner  Lecturer, Mental Health Nursing
              University of the West of Scotland
Dr Joyce Wilkinson  Research Fellow (public involvement)
                   St Andrew's University

Steering Group

Penny Bond  Professional Practice Development Officer
            NHS Quality Improvement Scotland
Robert Davidson  Interim Nurse Director,
                 Mental Health Partnership
                 NHS Greater Glasgow and Clyde
Sean Doherty  Team Manager
              NHS Quality Improvement Scotland
Therese Elliott  Communications Officer
                 NHS Quality Improvement Scotland
Susanne Forrest  Programme Director
                  Mental Health, NHS Education for Scotland
Margo Fyfe  CAMHS Nurse Advisor/Acting Mental Health
            & Learning Disabilities Nursing Officer
            Scottish Government
Alex McMahon  Head Mental Health Delivery Services Unit/
              Mental Health Nursing & Disability
              Scottish Government
Isabel Swan  Lead Nurse
            NHS Borders
David Thomson  Mental Health Project Manager
              NHS Quality Improvement Scotland
NHS Quality Improvement Scotland Support Team

Debbie Anderson  Practice Development Administrator
Pauline Donald  Practice Development Project Co-ordinator
Jenny Harbour  Health Information Scientist
Jeniffer Kibagendi  Equality and Diversity Officer
Karen McGeary  Communications and Publications Co-ordinator
Lakshmi Mandava  Health Services Researcher
Joyce Mouriki  Senior Public Partnership Officer
Annie Wright  Communications and Information Officer

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**NHS Quality Improvement Scotland**

Edinburgh Office
Elliott House, 8-10 Hillside Crescent, Edinburgh, EH7 5EA
Phone 0131 623 4300

Glasgow Office
Delta House, 50 West Nile Street, Glasgow G1 2NP
Phone 0141 225 6999

E-mail: qis.bestpracticestatements@nhs.net    website: www.nhshealthquality.org