STANDARD OPERATING PROCEDURE
CRISIS INTERVENTION TEAM FOR OLDER PEOPLE

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CHANGE RECORD

Version	Date	Change details
1.0	*Dec 2022*	*New SOP. Approved at MH Division Clinical (Practice) Network 07.12.2022.*
1.1	*April 2024*	*Reviewed with minor amends made. Approved at MH Division Clinical Practice Network (3 April 2024).*

Contents

1. INTRODUCTION

The Crisis Intervention Team for Older People (CITOP) is a specialist team who provide crisis intervention and intensive home-based treatment for older people experiencing either functional mental health problems or neurological conditions (e.g. dementia) who are registered with either a Hull or East Riding GP. Interventions are provided via telephone or face to face, in various community settings such as patients homes, care homes and trust bases. CITOP work alongside the Mental Health Advise and Support Team (MHAST) which offers 24/7 access for mental health support. For patients deemed to lack capacity regards their treatment and/or there are concerns about their safety and risk, CITOP may utilise the Mental Capacity Act (2005) or request assessment under the Mental Health Act (2007).

CITOP is part of the unplanned care division within older peoples services. The team work alongside a number of other teams and agencies. Including Mental Health Liaison Services (MHLS), the locality community mental health teams (CMHT), functional and organic Inpatient Services, Emergency Services, GP practices and Social care services. This collaboration aims to ensure comprehensive assessment of the persons health and social care needs allowing shared interventions and treatment that are agreed collaboratively with our patients The care is least restrictive, in a person's best interests, and often as an alternative to hospital treatment, or to facilitate earlier discharge from inpatient settings. It also follows the requirements detailed in the Five Year Forward View, (NHS England October 2014) and The NHS Long Term Plan (January 2019) to ensure smooth care pathways. CITOP have improved pathways within inpatient, urgent and community models as part of the Right Care Right Place Programme (2019/2020), Recovery and Trauma focussed agenda and wider Trust Pathways and remain congruent with the principles within the Mental Health Crisis Care Concordat.

What is a mental health crisis?
A crisis referral is someone whose needs and presentation require intervention and assessment within either 4 hours (Very high risk of imminent harm to self or others) or 24 hours (High risk of harm to self or others and / or high distress, especially in the absence of capable supports). Someone in mental health crisis will present with high levels of risk to self and others. Crises may vary in form- they may be developmental, situational, or as a result of severe trauma. Crisis services have been historically concerned with those crises associated with severe mental illness (Rosen, 1997-cited in Mental Health Topics, Crisis Resolution, Sainsbury Centre for Mental Health). The service user is likely to need intensive levels of engagement and intervention through clinical assessment and treatment that cannot be provided by local CMHTs.

Where there is immediate risk present, i.e. current actions which endanger self or others, overdose, active suicide attempt, violence and aggression or possession of a weapon, CITOP will notify the emergency services; Ambulance, Police and/or Fire Service. If the service user is on the telephone, the staff member will attempt to keep them online until emergency services arrive.

There are various possible causes or triggers of a crisis. For example, many people experience adverse life events that include a psychological, physical or social element, which leads to a need for an urgent or emergency response from mental health services. All crises will be different in their cause, presentation and progression. It is important to identify the trigger (for example, abuse, trauma or homelessness), associated risks and options for ongoing care, and respond to the crisis according to the individual's need and circumstances. Crisis is often a normal response to abnormal situations and events, distress if often the outcome of a crisis regardless of its source.

The team's purpose is to provide additional support and admission prevention to people who have presented to services in crisis or are under the care coordination of CMHT's and require a step up in care. This is in the form of crisis intervention and intensive home based treatment. This will be completed in a caring, supportive and holistic service to promote recovery and improve the lives of patients who are experiencing either functional mental health problems or neurological conditions (e.g. dementia), and their families. For those already open to mental health services this will be

based on the guidance and care plan of the patients care coordinator. CITOP is time limited service who provide crisis intervention for a short, identified amount of time. CITOP expect that care coordinators continue their role and any intervention will be agreed collaboratively with them. We aim to promote independence and care in the community wherever possible taking into account the needs, wishes and advanced statements of our patients and carers.

The nature of the team is such that it is not possible to cover all eventualities within this policy CITOP will need to consider the principles of this policy and other Trust policy and guidance when making decisions to best meet the needs of individual service users.

2. SCOPE

The purpose of this policy is to provide operational guidance for CITOP, which operates within the Humber Teaching NHS Foundation and should be followed accordingly. This document describes the aims, objectives, service model, service criteria, pathways, referral processes, response times, transfer of care processes, staff supervision, outcome measures and training in CITOP. It is the responsibility of the service manager to ensure that this policy is effectively implemented and escalate any issues as necessary.

3. DUTIES AND RESPONSIBILITIES

Discipline	Grade	WTE
Consultant Psychiatrist (shared with MVL)	0.5	
Team Leader	B7	1
Clinical Lead	B7 x 2	2
Specialist nurse	B6 x 9.8	9.8
Specialist OT	B6 x 1	1
Registered Mental Health Nurse	B5 x 2	2
Assistant psychologists	B5 x 2	2
Healthcare Assistant	B3 x 9.6	9.6
Administration assistant	B2 x 1	1

The team also includes other professionals to ensure we can meet the holistic needs of our patient group. This includes physiotherapy, medical secretaries and domestics. The team also are actively involved and supported by local authority staff.

PROFESSION ROLE

Service Manager – They will have overarching managerial responsibility for the running of the service and ensuring key performance indicators are met. The service manager will oversee any incident investigation and complaints procedures associated with the service.

Modern Matron – They will have overarching clinical responsibility for the running of the service and delegate day to day clinical risk management and support with admission prevention.

Nurses
Provide physical and mental health nursing care, care coordination/case management, Mental Health Act/Mental Capacity Act assessments, nurse prescribing, clinical leadership, initial assessment, ongoing assessment, discharge planning, specialist intervention, risk review and management, documentation of presentation and risk, formulation.

Consultant Psychiatrists
Provide Mental Health Act/Mental Capacity Act assessments, complex assessments and interventions, prescribing, supervision and advice to team members, clinical leadership, initial assessment, advice on difficult clinical issues, monitoring of team function (including metrics), minimal role in follow-up, ensuring seamless transition when junior medical staff change, other doctors' initial assessment, ongoing assessment, specialist assessment/management follow-up advice on difficult clinical issues and diagnosis.

Psychologists
Provide clinical leadership, initial assessment, specialist assessment and management follow-up, discharge planning, will be involved with a range of psychological interventions based on the initial formulation and activities, including neuropsychological assessment and rehabilitation, from face-to-face patient work with individuals and families, group work, Mental Capacity Act assessments, co-working, skills-sharing, teaching, working with practice development facilitators, supervision, audit, research and service developments.

Assistant Psychologists
Deliver psychology interventions as an outreach service or 1-1, alternative to the Acute Community Service (ACS), provide emotional support, collate information required for assessment and formulation. Undertake specialist neuropsychological assessments and preparation of neuropsychological reports. Contribute to MDT meetings, and, collect information for service evaluation

Health Care Assistants Provide essential physical health care, therapeutic interventions, monitoring, providing emotional and practical support, encouraging social participation, role modelling, follow-up supporting leave form the inpatient settings.

OT – CITOP has one specialist occupational therapist who receives referrals via multi-disciplinary team discussion during the daily review or referral checklist though email. The occupational therapist follows the Model of Human Occupation (MOHO) as a model of practice. The occupational therapist has two standardised MOHO assessments; the Occupational Self-Assessment (OSA) and Model of Human Occupation Screening Tool (MOHOST) and Pool Activity Level (PAL). Additionally, the occupational therapist completes activities of daily living and home assessments using trust approved assessment format. The occupational therapist can also provide occupational intervention for example routine and structure or graded exposure.

Physiotherapy
Provision – We are able to refer into physiotherapy services for support although this intervention may not be carried out during a person's time with CITOP. This will be coordinated through a care coordinator.
Reference: https://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf

To support all Staff the service ensures everyone has an allocated supervisor, has access to reflection sessions, informal and formal incident reviews and a service specific induction pack and competencies pathway. The service also facilitates monthly staff meetings and ensure staff have access to additional meetings to meet their professionals needs.

4. PROCEDURES

4.1. Hours of Operation

CITOP work 7 days per week, 365 days a year between the hours of 8am and midnight. Outside these hours calls are transferred to the trust's adult crisis team for support. Each shift will have a specialist nurse as shift co-ordinator a second qualified or equivalent and a healthcare assistant.

4.2. Service Model

The service will provide appropriate and comprehensive assessment. In the case of an identified functional mental health need the functional pathway will be followed and formulation/management plans will be considered for those with complex needs. Whereas in the case of the identification of an organic and complex need, the organic pathway will be followed.

Each individual and their care needs are discussed every morning in the team's daily clinical review. This allows us to review the patients' needs and update intervention plans, as well as to capture decision making including admission consideration. This is recorded on the daily clinical review sheets within the communication tab. CITOP do not have a weekly MDT given the rapid changing nature of the work we undertake. It is within the morning review that it will be agreed if anyone needs reviewing by the teams consultant psychiatrist, and the appointment booked in.

The team utilise an electronic board to allocate intervention and ensure all staff are up to date with clinical activity. The board has different sections dependent on need as follows:

Black Board – this is for patients who are a new referral and are awaiting initial assessment / contact, patients on leave from inpatient units requiring support, service users who are in the general hospital and patients attending the Acute community service who require additional support outside of those services hours of operation. Patients on this board will be visited by qualified staff if first contact or initial assessment. Other professionals may provide support if this is care planned leave.

Red Board – this is for those experiencing a crisis and requiring daily intervention by the team, or those who have outstanding assessments or paperwork. Patients on this board will be visited by qualified staff, however, a second visit may be completed by healthcare assistants to follow a care planned intervention i.e. care home role modelling, social inclusion, behavioural activation.

Amber Board – This is for those whose mental health needs are requiring a less intensive intervention plan, who are following a specific piece of care planned intervention, or those whos' discharge planning is underway. All staff can visit these patients, this will be discussed in the clinical review and allocated by the shift co-ordinator.

Service users are moved between boards depending on their presentation and associated risk, this is completed during daily clinical review after discussion within the team. When a service user moves between zones during their time with CITOP the FACE risk assessment will be updated, the responsibility for this documentation update will be allocated following clinical review and overseen by the shift co-ordinator.

4.3. Referral Procedures

Referrals to the team may come via two pathways as set out below

Service users open to a care coordinator within CMHT

Care coordinator or duty nurse will contact CITOP for a clinical discussion in relation to the service users needs and associated risk. All referrals are discussed with a clinical lead and when agreed the referrer will complete a care plan that specifies the reason for referral, what interventions are

being requested and a time scale for that intervention. The referrer also needs to ensure that the FACE is updated including relevant to changes in risk. At the point of referral it will be agreed when the first contact between CITOP and the service user will be, this should be joint with the care coordinator wherever possible.

CMHT staff will place a referral on Lorenzo to CITOP which will be accepted by the team.

New referrals to the team
CITOP can receive referrals via an urgent referral line, which is manned by the CITOP shift co-ordinator and situated in the team main office. The urgent referral line is for GP's, police or paramedics who have concerns for a person's wellbeing and feel an urgent response is required. Service users referred via this line will be triaged during the call, at this point the referral will then be either accepted or rejected and a response time is decided upon by the team.

At the point of acceptance, a referral will be created on Lorenzo and accepted by the team. at this point a referral is also created to the relevant CMHT if indicated. All referrals to CMHT from CITOP are to be accepted within 72 hours.

Outside of CITOP working hours (8am- Midnight) the urgent referral line and the CITOP team phone lines are transferred to adult crisis services and managed within that service. The adult service are the decision makers for these referrals and will make contact with CITOP the following day where appropriate.

New referrals can also be made by the Mental Health Liaison Service (MHLS) who are a specialist team based in the Emergency Department (ED) at Hull Royal Infirmary. They provide a valuable role in supporting people in a crisis, as well as adults and older adults who have both mental and physical health problems in a general hospital setting. The assessing practitioner will contact CITOP for a clinical discussion in relation to the service users needs and associated risk. Once the referral is accepted an electronic referral will be placed on Lorenzo. MHLS will have completed an initial assessment document, FACE and cluster.

Referral response should be based on the Clinical Triage Risk Decision Guidance (UK Mental Health Triage Scale)

Prioritise response based on the presenting need and level of urgency.
See below and appendix 3 & 4

A-Emergency immediate blue light 999/ A&E
Immediate response - denotes emergency situations in which there is imminent risk to life or serious harm to themselves or others, and will require a '999' response, potentially within minutes
B-Very Urgent – within 4 Hours
For those who present a very high risk of harm to themselves or others, acute suicidal ideation with clear plan and intent, who have a rapidly worsening mental state, who do not require immediate physical health medical intervention, are not threatening violence to others.
These referrals require a very urgent assessment with a specialist mental health crisis practitioner within four hours.
C-Urgent-within 24 hours
The types of typical presentations in this category include high risk behaviour due to mental health symptoms, new or increasing psychiatric symptoms that require timely intervention to prevent full relapse and/or significantly impaired ability for completing activities of daily living or vulnerability due to mental illness, expressing suicidal ideation but no plan or clear intent.
These referrals require an urgent assessment with a specialist mental health crisis practitioner within 24 hours.
D-Semi-urgent -within 72 hours
The types of typical presentations in this category include moderate risk behaviour due to mental health symptoms, new or increasing psychiatric symptoms that require timely intervention to

prevent full relapse and/or significantly impaired ability for completing activities of daily living or vulnerability due to mental illness, expressing suicidal ideation but no plan or clear intent.
These referrals require a semi-urgent assessment with a specialist mental health crisis practitioner within 72 hours.

What needs to be completed for every assessment:

Functional
• The initial assessment form
• FACE
• Cluster
• ReQol/GDS/SAST
• Consent form
• Safety Plan
• Interim Care Plan
• A contact needs to be recorded on Lorenzo
• Assessment/risk assessment needs to be distributed to GP

Organic
• The initial assessment form
• FACE
• Capacity assessment for CITOP input
• Best interests form
• Interim Care Plan
• ABC charts/Traffic light forms (care homes)
• Challenging Behaviour Charts CBS (care homes)
• A contact needs to be recorded on Lorenzo
• Assessment/risk assessment needs to be distributed to GP

Following assessment all paperwork is required to be completed on Lorenzo, outcomes could be:
1) Transfer of care to an in-Patient Unit for mental health care
2) Home Based Treatment
3) Acute Community Service referral see ACS SOP for process.
4) Referral to Locality Team Community Mental Health Team (CMHT)
5) Referral to primary care, third sector, Improving Access to Psychological Therapies (IAPT).

Interpreter Requirements
The team have access to Language Line-Insight which is a real time video interpretation services. Staff have access to their work smart phones or the team IPAD. Should there be a preference or requirement of face to face in person interpretation services that this can be arranged

High Risk Calls
When dealing with difficult, high risk calls, staff have access to a range of support options in obtaining appropriate assistance. This includes:
• Informing the caller that the staff member may need to speak (for advice) to a colleague while they stay on the phone.
• Flag (wave arm etc.,) with a colleague/Co-ordinator that they need support/advise.
• Staff may need support from another member of staff to take over the call.
• Have a clinical discussion and develop a Crisis/safety plan.
• Consider a mental health assessment.
• If the call handler wishes for the police to be contacted, they will be required to either inform another member of staff (see above) or contact the police themselves.
Staff will use their clinical judgment to make use of the above options and record as appropriate.

If the staff member is an unregistered member of staff, and during a call there is a clear imminent risk of suicide please follow the UK MH Triage Scale appendices 3,4,4a.
Staff are to ensure they seek supervision and time to reflect after such calls.
Further support can be found in the staff induction pack

Frequent callers/users of the service
Some of the service users that have contact with the service on a regular basis often present with complex needs and at times the service can find it challenging to effectively support them. The team will identify alongside the CITOP clinical leads, service users who may need a behavioural management plan to support staff with interventions and interactions. CITOP will link in with the older peoples psychology team to develop this, which will discussed and shared will all involved in that persons care.

Service user under the influence of substances
The service users who present intoxicated or following an overdose (both prescribed and non-prescribed) should be determined at the earliest point in the contact, When the service user is presenting as intoxicated/overdose with substances (prescribed and non-prescribed), the Intoxication Pathway must be consulted and the Symptoms and Signs of drugs involved in poisoning or overdose, must also be consulted. The pathways should be utilised to support clinical decision making and ongoing management of the service user.

The Gate keeping process (Refer to the Bed Management for further details)

Providing a compassionate, supportive, and least restrictive response
In the Older Peoples Mental Health Services, lead on the process of gatekeeping and will be at the forefront of these decisions as ultimately, they need to decide if a community alternative is safe and viable. Gatekeeping is the process of a clinically focussed intervention completed by clinicians in order to facilitate the most appropriate, least restrictive outcome to meet the needs of the patient. The Bed Management Team can be involved in the process in respect of balancing capacity and demand. The process is in place to ensure equity to access appropriate care in the correct setting which supports the patient, their family & carer(s).

Aim of Gatekeeping process
The primary objective for CITOP is to minimise harms including harm to self, harm to others, harm from others and potential unintended harms from our intervention and to help support the individual in their recovery and minimise distress using a bio psychosocial model. The team can enable people to be transferred earlier from inpatient wards and receive treatment within their homes (alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress. Many service users and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based' treatment are at least as good as those achieved in hospital. 'Intensive' home treatment can be provided in a range of settings.

Consideration of options
CITOP will consider all of the options available and consider working collaboratively to find the best outcome. with patients and carers to help the individual to support their recovery, promote stabilisation of mental health and address potential risk. CITOP will also consider whether referral to ACS is a suitable alternative to admission.
We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both.

There may be circumstances where the face to face gatekeeping process is not required, as community treatment is not deemed as a viable alternative to inpatient care. Examples of these could be:

- Service users recalled on Community Treatment Orders
- Service users on leave under section 17 of the Mental Health Act (MHA) 1983
- Planned transfer of cares from Specialist Units.
- Where a Mental Health Act assessment has already taken place.
- If a Doctor has commenced the recommendations of a MHA section and then the service user agrees to an informal transfer of care. As the Doctor has already begun to carry out an assessment and has felt that formal transfer of care would be appropriate it would not be clinically appropriate for the Service User to be seen by CITOP staff and may delay the service user receiving appropriate care and treatment.
- Planned transfer of cares for service users who are returning from out of area (their initial transfer of care will have been expected to have been gate kept).
- Planned transfer of cares for service users who are returning from a short transfer of care to the acute trust from one of our wards, where the plan was for the service user to return to the ward once treatment was completed by the acute trust.

Expectations from Referral Routes:

MHLS
It is expected that a conversation between MHLS assessing clinician will occur with CITOP to explore the reasons for referral for admission and to explore all least restrictive options, providing an opportunity to assess for HBT interventions. A further face to face gatekeeping assessment will not be required, as the patients has already been assessed by an appropriately skilled clinician, during their crisis situation. The receiving clinician should not insist on awaiting completion of all paperwork before this discussion is had, as this can cause unnecessary delays to the patient's care, identification of intervention and impact on capacity/waiting times in A&E. The patient will have completed any treatment and therefore either medically fit or expected to be medically fit for discharge when this contact occurs.

Management of violence and aggressive (See Management of Violence and Aggression Policy). Always discuss and agree response to individual needs within the MDT.

Requests for people to be assessed under the Mental Health Act

Mental Health Act Assessments are considered and coordinated in Hull through MHCIT and in East Riding through Adult Social Care.

Providing support for people in the community pending an assessment under the Mental Health Act
A core function of CITOP is to undertake or delegate the gatekeeping of all admissions to acute adult mental health inpatient units.
CITOP will provide and coordinate interim support arrangements as an alternative whilst an assessment is being considered and if appropriate undertaken. If under the person is under the care of a mental health, this should be a shared plan with that team. If the person is refusing to engage with services, CITOP will remain the central service for coordinating support and ensuring family and carers where applicable are supported.
All information will be robustly communicated between services and the need for admission may be escalated. Where an inpatient admission has been agreed via the CITOP gate keeping function, but a bed is not immediately available, CITOP will be responsible for coordinating and providing support to the service user and their family and carers who are in the community.
If waiting for a bed for more than 24 hours CITOP will complete an Incident Report (Datix). Support will involve (where appropriate) effective collaboration between all parties which may include the service user's lead practitioner, AMHP and any or all of the service user's support network. All practitioners (regardless of service) must ensure effective communication is kept at all times. The nature and degree of support and rationale for decision making must without exception be fully documented on case notes and contact will be at least daily. The necessity for hospital admission

will be reviewed at each contact by each visiting clinician (regardless of service) within the agreed and documented collaborative support plan.
Any service user in the community and being supported by CITOP whilst waiting for admission will be discussed during the CITOP handovers. The team will liaise with the Bed Management Team. All service users awaiting admission and with the agreed support in place will be discussed within the (Daily bed meeting?) If CITOP (with others where appropriate) are unable to safely support a service user in the community, they will immediately escalate concerns to senior management. CITOP may have to increase the intensity of contacts and support from other parts of the Mental Health Division.

Mental Capacity Act
As per the Mental Capacity Act 2015, it is assumed that every adult over 16 has full legal capacity to make decisions for themselves at the time that the decision needs to be made.
However, where capacity is doubted, or following assessment deemed to be absent, we need to capture this decision making. The best way of doing this is by completing the Mental Capacity Assessment form. This is located in the Mental Health Act and Legal Tab, then notes, in Lorenzo. Whilst documenting in a normal communication form can at times capture this, we are still prone to just stating that patient lacks capacity, rather than being more explicit in reasons for lack of capacity and more importantly with regards to which decision in particular the patient lacks the capacity to make.
There have been a series of SEA's and investigations in the Trust where we have made this error, and this has led to further issues and complications.
By completing a Capacity Assessment form, we can fully capture if someone has or lacks capacity for a specific decision, this will give the individual practitioner a lot more cover and security in the event of an untoward incident. Here are a few examples when we should consider undertaking a capacity assessment and documenting it on the relevant form.
1. If making a decision to admit someone informally, but there was some doubt as to whether the patient had the capacity to consent to that admission or not, the Capacity Assessment form can be completed, with the decision being 'Should patient A be admitted informally to inpatient unit B". The decision maker is the person undertaking the assessment. The form is actually quite straightforward but means that we can capture the specifics of how you came to confirm the patient had capacity or indeed lacks it. One can also consider use of copy and paste into any communication sheet being completed as well.

A completed capacity form will help when there is a risk that the admitting unit are querying capacity when the bed is initially being arranged. Remember that the capacity assessment is time and decision specific, so it would not be an issue if when assessment is carried out, they have capacity but this changes in the future.

Lone working procedure on and off site
Risks should be identified at the point of receipt of referral, in regard to risk to the member of staff. These risks can be personal (directly from the service user) from a carer or known associate or may be environmental. Due to risks posed by service user contact within a hospital and community setting, lone working procedures should always be adhered too. Please see HFTT Lone working policy.
Local protocols from lone working are as follows:

- When risk to visiting is identified, this should be recorded as an alert on Lorenzo and the sections of the referral (appendix 8) and triage (appendix 15) should be completed to document the risk identified and what protocols will be put in place to manage this.
- When risks to visiting are identified, the preference would be to see the service user at a team base and where possible. This is not always possible due to presentation and in these instances the following should be adhered to:
- The staff member should indicate on the staff signing in/out boards in the CITOP main office, the address of where they are going, the service user whom they are going to see, time of departure, time of expected arrival back at base, and a contact number they will be available on. Where there is no whiteboard to place information onto, the staff member should contact

the shift coordinator, or designated other person, and inform them of the information listed verbally. The person receiving the information should document this for their records. The shift coordinator should always be made aware of a staff member leaving site and attending a service users' home/another site.

- The shift coordinator should then contact the staff member on the contact number provided if they do not return/contact you by the time estimated.
- The staff member should make every effort to contact the coordinator to inform them if the plan changes/time changes or there is new information that has come to light.
- In certain circumstances, the staff member may not be able to contact the coordinator due to presentation of the service user and in these instances should follow the trusts Lone Working Policy and escalate the situation as required.
- Should the staff member not return to site and be uncontactable, the coordinator is to raise this to clinical lead on duty or on call manager and consider the use of contacting next of kin and the police.
- When seeing a service user on a trust site, lone working procedures should continue to be adhered to.
    - Service user should be seen in an appropriate room on the site.
    - Staff member should ensure they have surveyed their environment before inviting in the service user and take note of exits, chair positioning and alarm systems.
    - Staff member should always remain in close proximity to the entrance to the room and any alarm points available
    - Should risk escalate, the staff member should attempt de-escalation if appropriate and/or remove themselves from the room to protect their safety. Staff to use the alarm points to contact for help as required.
    - Staff should ensure they have enquired about and adhere to all local procedures at other sites they may be working from.
- Staff should always consider the use of a second person attending visits and assessments with the staff member and arrange this accordingly.
- There may be occassions that staffing numbers are decreased leaving lone practitioners on site. Should this be the case then staff on duty are required to update Mill View lodge nurse in charge. The role of ensuring staff are safe then falls to the nurse in charge on MVL i.e contacting staff after no return within agreed time scheme. Staff should also ensure that the Main building entrance is used and not the CITOP entrance located to the side of the building.

Any incidents of aggression should be documented on Lorenzo, including creating an alert, inform the shift coordinator/clinical lead, report via Datix, consider report to the police as required. Staff who witness or are subject to physical or verbal aggression should be offered supervision and a de-brief session at the earliest opportunity.

4.4. Involving Patients, Carers and Families

We strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. We recognise however that some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk.

We want to emphasise to practitioners that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk, they should use their professional judgement to determine what is in the person's best interest. Part of the assessment should always take place without the carer of family member present. This is to enable the Service User to disclose information that they do not wish others to know.

CITOP complete a reception meeting as part of the assessment process, this is completed with a family member or friend to gain their perspective on the service users presentation, needs and historical factors. We provide information to carers/families/relevant others to support care in the community whilst maintaining the patients' quality of life and respecting their values and beliefs.

The team will assist patients or families/carers to access additional support as indicated via social care.

Patients who have experienced our services first hand, their families and carer(s) are best placed to help us develop, monitor and improve services. To help us better understand the quality and effectiveness of our services we collect information about the service including; complaints, compliments and contribute to the national Friends & Family Test surveys. The organisation has a Patient Advice and Liaison Service**,** known as PALS, which helps us to listen to patients, their relatives, carers and friends. The team carries out bespoke surveys at the initial meeting and reviews as well as on discharge. The care group takes opportunities in its developmental work to assess patient, carer and family feedback through a specific Patient and Carer Experience Group.

4.5. Transfer of Care

Following the referral of service users open to the CMHT, CITOP will expect collaborative working throughout their period of care and care planning support from the care co-ordinator. Patients care will be stepped back down to the care co-ordinator following a clinical discussion within the daily clinical review meeting when their treatment is complete or risks reduce.

The intention to transfer care will be communicated and discussed with the care coordinator and a joint visit will be agreed as best practice. CITOP will contact the care coordinator to arrange this visit. CITOP will then contact the patient to confirm the meeting time and date. Following the joint visit CITOP will complete FACE, cluster and update GP of discharge. The patient will then require a 72 hour follow up visit from the care coordinator as per CMHT SOP

Where the patient is new to services, and a referral to CMHT felt appropriate, this will be done and allocated within the KPI timeframe. Following care co-ordinator allocation. The above transfer of care process would then apply.

If it is agreed by CITOP MDT that the patient can be closed by secondary services, or signposted to a primary care service, they will be transferred back to the care of their GP. The nurse from CITOP will update the FACE, Cluster and send a letter to the GP within the agreed KPI of 72 hours.

5. REFERENCES

Reference should be made here to any other associated relevant Trust strategies/policies/guidelines or documents.