**Crisis Resolution and Home Treatment Triage Tool**

* This tool is intended to be used as an aide memoire and prompt for those taking initial calls about those people presenting in crisis, and for the initial crisis responders attending to that patient’s needs.
* It is not intended to be prescriptive, or exhaustive.
* It is a scribble sheet for you to capture information on in the form of notes, in order that this can be transferred onto Paris. This should then be shredded once that has occurred.
* Should you be talking to the patient in crisis, it is not anticipated that any of the questions such as; ethnicity, NHS or Paris ID would be asked.
* The essential questions are highlighted with a bold box around them. These are essential as they can help locate the person should any phone connection be lost.

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| **Key patient information**[Shaded area are essential information fields] |
| **Referral Date** |  | **Time of Referral** |  |
| **Referrer Name** **& address** **(& speciality if professional)** |  | **Referrer Contact number(s)** |  |
| **Person completing the telephone triage** |  | **Gender** | **Male/Female/Transgender/Other** |
| **Patient Name** (known as/preferred name) |  | **Date of Birth** |  |
| **Religion** |  |
| **Ethnic Origin** |  |
| **Paris ID** |  | **Marital Status** |  |
| **NHS Number** |  | **Telephone number(s)** |  |
| **Patient Address:** **Postcode:** |
| **Current location of patient:** Consider environmental risks | **Telephone number at location:** |
| **Known to services?** Which service & keyworker?Diagnosis detail | **Yes/No** | **Existing Safety plan and risk assessment (from any service)?** | **Yes/No** |
| **Patient’s GP contact details**Name, address & telephone number |  | **Key risk management & safety actions from plan/s:** |
| **GP aware of referral?** | **Yes/No** |
| **Does the patient have mental capacity to make decisions about their own care?** | **Yes/No** | **Patient/Parent/Carer aware of referral?** | **Yes/No** |
| **Has the patient/parent/carer consented to the referral?**(If no consent, try to engage with service user to gain consent. If consent not gained consider MH Act Assessment) |  **Yes/No** | **Consent to speak to Carer?** | **Yes/No** |
| **Parent/carer/next of kin details**(name, address & telephone) |  | Document who has **parental responsibility** (for all under 16) or **lasting** **power of attorney** NB: S136, ST,FCR |  |
| **Relationship of carer to patient** |  |
| **Translator (**incl BSL) **required**  | **Yes/No** | **Language required** |  |
| **Disability** | **Yes/No****Details:** |
| **Consent to contact GP for information?** | **Yes/No** |
| **Information entered onto Paris?** | **Yes/No** | **Date** |  |

**Telephone & Responder Initial Assessment**

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| **S** | **Describe the situation:*** Reason for referral/aims of involvement
* Crisis assessment/home treatment.
* Social/care package/network support, marital status, vulnerability
* Housing, debts, benefits?
* Any safeguarding concerns?
* CYP: Looked after children status
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| **B** | **Describe the** **background:*** A brief history,
* Events leading up to the referral,
* Any past psychiatric history,
* Additional needs/disability (learning/physical incl autism/Asperger’s)
* Does the patient have a carer?
* What is the support network for the patient (family, friends etc)
* Perinatal?
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| **A** | **Assessment**:* Symptoms, presentation, mental state.
* Current medication (including dose, frequency, are they taking as prescribed)
* Any known allergies?
* Identified risk factors to self & others/DSH/forensic

/vulnerability* Cognition,
* Resilience.
* Orientation to time & place
 |  | Violence towards others |  |
| Suicide |  |
| Self-harm/OD |  |
| Self-neglect |  |
| Drug & alcohol use |  |
| Actuarial data i.e. age gender midlife stresses, isolation etc. |  |
| Physical health needs |  |
| **MHSOP Organic / Learning Disabilities:****P**ain**I**nfection**N**utrition**C**onstipation**H**ydration**M**edication**E**nvironment* Sensory deprivation
* Lying/standing BP
* Delirium screen
* Orientation to time and place?
* Any known previous cognitive scores
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| **R** | **Recommendation of which risk category and reason for decision:** |
| **High Risk** | **Medium Risk** | **Low Risk** |
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| **D** | **Decision** of the **plan of action**; 4hr crisis assessment, home treatment, safety plan, risk and short term intervention/follow up (eg. IHTT/CMHT etc):  |

| **Emergency** | **Urgent****(Urgent and Urgent)** | **Routine****(Routine and booked)** |
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| **Risk:**Deterioration in mental state and associated risks.Presenting with immediate risks of harm to self or others.Overdose/suicide attempt/violent or aggressive Possession of a weapon  | **Risk:**Deterioration in mental state and associated risks.Presenting with a high/moderate risk of harm to self or others. Gatekeeping assessment. | **Risk:**Deteriorating mental state, however, associated risks are low .**Presentation:**Requires specialist mental health assessment but is stable and at low risk of harm during waiting period. Other services able to support or provide care for the person until mental health service assessment (+/- telephone advice). Known service user requiring non urgent review, adjustment of treatment or follow up. (CPA)Referral for diagnosis.Requests for capacity ***(if required to inform immediate treatment and care)*** assessment, service access for dementia or service review/carer support. |
| **Presentation:** | **Presentation:**Suicidal ideation with plan or ongoing history of suicidal ideas with possible intent. Rapidly increasing symptoms of psychosis and/or severe mood disorder.High risk behaviour associated with perceptual or thought disturbance, delirium, dementia or impaired impulse control.Risk due to significant cognitive impairment.Vulnerable; isolation or abuse in association with mental health presentation.Deteriorating mental health state in perinatal presentation, lower threshold in regards to crisis response.All of the above is inclusive of those people with Learning Disability. |
| **Not known to service** | **Known to service** Liaise with associated practitioner/duty responder during where available to offer responseAccess use of Crisis Plan |
| **Service response:**Police, Health Professional and/or ambulance response requestedStreet Triage | **Service response:****4 hour**Face to face assessment & plan for safe care by local crisis response worker | **Service response :****4 hour**Face to face assessment & plan for safe care by local crisis response worker/associated practitioner | **Service response:**Booked onto service duty desk for access to service appointment**NB This only applies to patients already open to services** |

**Triage for Home Treatment Indicator**

**Criteria for Acceptance**

**Triage for Crisis Response Indicator**

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| **Purpose:**Support people through mental health crisis, where additional support is required to promote recovery, reduce risk or help maintain safety AND the individual requires more frequent/intensive input than is being delivered as part of their current care plan. |
| **Presentation:**Assessment or review of mental health state and risks completed by care coordinator/associated practitioner indicating a need for Home Intensive Treatment.Evidence that a CMHT have increased support within their capacity prior to referral. Patient and carers can self-refer to Home Intensive Treatment if open to secondary services. |
| **Service response:**Face to face intervention within timescales agreed with service user and referrer but no later than 24 hours. |