Acute Care Team

Model of Care

Models of Care set the Standard for Care

Metro South
Addiction and Mental Health Services

NGOs  1300 MH CALL  AMHS  Primary Care

Resource and Access Service
Academic Clinical Unit
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Metro South Addiction and Mental Health Services

Our vision
Provide our community excellence in patient and family-centred, integrated services across the continuum of addiction and mental health care.

Our mission
Demonstrate exceptional care to patients experiencing addiction and/or mental health problems to reduce the burden of disease and to integrate care with our key health partners.

Our core values
Metro South Health Addiction and Mental Health Services has six core values that define and determine how we embrace our day-to-day work.

1. Courage
To challenge what is the status quo and lead change.

2. Leadership
To guide with purpose and direction through acceptance of responsibility and accountability for the services we provide.

3. Team work
We work in a supportive, transparent, responsible and answerable manner.

4. Respect
We treat patients, families, carers and staff with equality and consideration.

5. Integrity
We demonstrate honesty, loyalty and sincerity.

6. Caring for people
To help, assist and guide individuals to achieve their goals.

Our service culture is based on the focused delivery of care to patients, their families and carers, within a framework that encourages hope and the building of resilience.

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Introduction

The Acute Care Teams (ACT) deliver a face-to-face point of contact to Metro South Addiction and Mental Health Services (MSAMHS). ACT obtains service requests from the 1300 MH CALL triage and other mental health services based upon urgency and prioritisation of care. Following a face-to-face assessment ACT facilitates the most appropriate type of care (e.g. time limited, inpatient, community, crisis interventions) for the individual. ACT provides a multidisciplinary mental health service to consumers with acute care needs in a community setting. The majority of ACT service provision is outreach, occurring in the consumer’s home, a community clinic, a general practice (GP) or other nominated place.

The key functions of the ACT are:

- timely assessment and clinical interventions that lead to initial recovery planning, including relapse prevention and implementation for community consumers presenting with acute mental health needs
- facilitation of access to the most appropriate mental health care—public mental health care and/or mainstream health care.

ACT functions contribute to:

- ensuring ease of accessibility, in a timely manner to mental health services
- providing assessment and short term acute mental health care in the community
- facilitating onward referral to the most appropriate services
- supporting community mental health teams to provide consumers and carers with short-term, crisis care.
ACT tasks include:

- providing information and advice to health care providers on the provision of mental health care
- establishing effective, collaborative partnerships with other mental health services/teams, local ED services/teams, external service providers and agencies (e.g. general practitioners, the Queensland Police Service, alcohol, and other drugs services (ADS))
- providing timely responses to mental health crisis presentations
- establishing a detailed understanding of local resources for the support of individuals with mental health problems
- involving patients and their carers in all phases of care and supporting them in their navigation of the mental health service system
- providing safe, high quality assessments and interventions that demonstrate best practice principles and reflect evidenced based care
- supporting health promotion, prevention and early intervention strategies.

Following referral from 1300 MH CALL, ACT completes a face-to-face assessment within the specified time and/or delivers time limited interventions. ACT will also facilitate the referral of the consumer to a more appropriate internal and/or external service such as a community mental health team, an alcohol and drug service or primary health care.

ACT primarily focuses on the acute care needs of newly referred adult consumers to the service. Locally, consumers of particular age groups (children, adolescents, older adults) are referred to predetermined age specific services. A range of other factors (e.g. cultural appropriateness) will also be considered with respect to the onward referral process.

ACT also provides, or co-provides, short term follow-up and community-based intensive care to some consumers in the immediate post-discharge phase from an adult acute inpatient psychiatry unit and to consumers of a community care team that require intensive acute care support.

Service provision under these circumstances are pre-planned during the intervention period and ACT referral acceptance is on a case by case basis.
Key Clinical Tasks

1. Working with other services

Key elements
- Strong partnerships will be initiated and maintained with other health and mental health service providers.
- When more than one service provider is involved in service delivery, ACT will initiate and participate in discussions around which service will adopt the role of lead service provider.
- When consumers have specific needs (e.g., sensory impairment, transcultural) to ensure effective communication, ACT will engage the assistance of appropriate services.

Comments
- This includes regular contact and clear communication processes throughout all phases of consumer care.
- Formal agreements will be developed where possible.
- The ACT will work in close collaboration with other service providers to meet individual consumer’s needs.
- Advice, education, and support on mental health issues are provided to other services.
- Certain population groups require specific consideration and collaborative support. This includes people from Culturally and Linguistically Diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people.
2. Referral, access and triage

Key elements

1300 MH CALL is a single point of contact, statewide mental health triage service specific to Queensland Health.

- Timeframes for face-to-face assessments referred by 1300 MH CALL to ACT are formulated according to the documented Mental Health Triage Rating Scale. Every effort is made to meet the timeframes specified.
- ACT staff make every effort to prevent delay in admission to the inpatient unit from ACT.
- A timely written referral is provided for direct referrals from ACT to all other service providers (e.g. GP, non-government organisations (NGOs), community health).
- Referrals, including written documentation, may be made to the ACT for acute care in the immediate post-discharge phase of an inpatient admission. These cases will require a referral (from the acute inpatient service) to have been accepted by the service that is going to provide longer term care (e.g. community care team).

Comments

- In the event the assessment by the ACT is not undertaken within the stated timeframe, a clinical review with an updated risk assessment will be documented, detailing the clinical indicators for the change to the planned assessment.
- Joint protocols with clear local pathways of care between ACT and the inpatient unit will be in place.
- Communication will occur on the same day for crisis assessments. This will support continuity of care for the consumer and ensure the early engagement of all service providers in ongoing care.
- Not all community care teams provide seven day a week care. The role of the ACT in these circumstances is to provide interim, short-term acute care on-demand.
3. Assessment

Key elements

- A comprehensive mental health assessment is conducted for all referrals triaged as requiring, or potentially requiring, mental health care.
- Risk assessments will be conducted at assessment, as clinically indicated in all phases of care provision. A risk assessment will be documented prior to transfer or discharge. Risk assessments include a formalised suicide risk assessment.
- Routine assessments will be timely, reflecting the clinical needs of individual patients.
- Assessments of Indigenous people presenting to mental health services will include, if determined by the patient, indigenous representation/support.
- Assessments of alcohol and drug use will be undertaken with every new patient, and routinely throughout ongoing contact with the service.
- Physical health will be routinely assessed and documented. This may be conducted by a health service provider external to the ACT, but needs to be considered as part of ACT assessment.
- Assessments will typically be conducted in the community, if it is safe and suited to individual need.
- The outcome of assessments will be communicated to the patient, carers and other care providers, in an appropriate and timely manner.
- Family/carers/significant others will have their needs assessed and addressed as indicated and/or requested.
- Child safety issues will be addressed in accordance with the appropriate statewide protocols, policies and procedures (QHEPS).

Comments

- All risk assessments are recorded in the Consumer Integrated Mental Health Application (CIMHA). In the initial assessment the risk assessment is conducted as one component of a comprehensive mental health assessment.
- Risk management procedures are consistent with the clinician’s professional and ethical obligations, and MSAMHS policy (QHEPS/intranet).
- 1300 MH CALL time from referral to face-to-face assessment is prioritised.
to meet the Mental Health Triage Scale response time.

- In the event a patient identifies as Indigenous, a referral will be made directly to the Indigenous mental health team/worker, to provide or participate in the initial assessment and ongoing service. A range of culturally appropriate services and strategies will be available to support the safety and integration of culturally competent care across service settings.

- Detection of alcohol and drug use problems will be incorporated into the recovery plan/individual care treatment plan form.

- Documented evidence of the physical health assessment will be recorded on CIMHA.

- All efforts will be made to ensure 100 percent of patients have a nominated GP.

- Patients will be actively supported to access primary healthcare and related health improvement services.

- Potential physical health problems will be identified and discussed with the patient, GP and/or other primary health care provider.

- Where significant obstacles to accessing primary care exist, the ACT will assist consumers to access the ED to provide physical health services.

- Referral to the hospital ED for assessment can occur, if indicated for safety or individual needs.

- Inter and intra service communication, including CIMHA records, will occur on the same day for crisis assessments.

- For all other assessments written or verbal communication will be completed within 48 hours of an ACT assessment. If only verbal communication is provided initially, written communication will then be provided within three business days.

- Policy statement and guidelines on the management of abuse and neglect of children and young people (0-18) is accessible on MSAMHS QHEPS intranet site.

4. Clinical Review

Key elements

- All new cases will be routinely discussed at a clinical intake review meeting within 24 hours of presentation and at multidisciplinary team reviews meetings (at least weekly).

- Adhoc case reviews will occur to address complex clinical issues and
following a critical event.

- Patients with high risk, crisis presentations and unstable needs are to be discussed by the multidisciplinary team daily.
- All multidisciplinary team reviews will be documented in the patient’s CIMHA record.
- Individual care/treatment and significant changes in intervention will be discussed at the multidisciplinary team reviews.
- Every patient’s progress and outcomes will be regularly monitored.

Comments

- A consultant psychiatrist or appropriate medical delegate will participate in daily clinical intake review meetings (this may be direct or via telehealth).
- A consultant psychiatrist will participate in all multidisciplinary team review meetings.
- The consultant psychiatrist or delegate will take responsibility for ensuring that assessments and management plans are adequate and that a process is in place to ensure that any onward referral is completed.
- A consultant psychiatrist will be in attendance at all case reviews. A case review will provide an in-depth review and a set agenda. All clinical discussion and notes from the review will be recorded in the clinical file and consumer care review summary.
- Critical events will be reviewed utilising the clinical incident management implementation standard.
- A highly visible up-to-date system will be maintained to manage this process (e.g. table on white-board).
- Patients who are stable, not high risk and have a clear treatment plan will be discussed at least weekly.
- Details of the initial multi-disciplinary team review will be documented into the patient care review summary including, clinical issues raised, treatment care plan, and those responsible for actions.
- Changes in treatment throughout the course of care will be discussed by the team and actions will be agreed to and assigned to specific clinicians and recorded in the clinical record, with reference to the initial care review summary.
- Any changes to the recovery plan will be done in collaboration with the
patient.

- Structured risk and review processes will be utilised as appropriate.
- Some components of the review process will include objective measurement tools, including but not limited to, routine outcome measures if clinically relevant.

5. Clinical Interventions

Key elements

- The majority of clinical care provided directly by the ACT to new patients will be able to be completed within 14 days of first contact.
- Clinical interventions, reviews and follow up processes will include a range of delivery methods to ensure safety and to update clinical care needs. They may include, but are not limited to, telephone, clinic appointments, home visits and input from non-clinical support workers or NGOs.
- All services provided by the ACT will be undertaken in conjunction with the patient’s GP where available.
- Patients will be supported to access a range of bio-psycho-social interventions which address their individual needs. Efficacy of treatment and progress will be reviewed and evaluated throughout the episode of care.
- Medication will be administered, prescribed and monitored as indicated by clinical need, involving a shared decision making process between the treating team, the consumer and significant others.
- Education and information will be provided to the patient, carers and significant others at all stages of contact with the service.
- Information and advice to address alcohol and drug use, if relevant, will be routinely provided. For some patients’, alternative or additional support is required.
- Involvement of carers and families is recognised as integral to patient engagement and is associated with better clinical outcomes.
- Time to provide emotional support to the patient and carer/s needs to be given adequate priority.
Comments

• It is anticipated that some people will need to remain within the ACT service for four to six weeks.
• The extent and type of follow up methods will specifically align with clinical need and acuity levels.
• ACT will proactively provide interventions utilising case coordination to provide assertive engagement and follow-up.
• Every effort will be made to link 100 per cent of patients to a GP. The ACT will communicate and work in collaboration with the GP throughout the care provision.
• A range of short-term, evidence-based, brief intervention models and techniques may be utilised to reduce the severity of symptoms and increase resilience to cope with mental health problems (e.g. cognitive behavioural therapy (CBT), structured problem solving, motivational interviewing, psycho-education, psychopharmacological treatments).
• Interventions will be based on recovery principles.
• Multidisciplinary input will be provided to optimise patient recovery.
• Interventions will include relapse prevention programs/techniques.
• Patient and carer support interventions will be integrated.
• Across all treatment settings all prescriptions, dispensing and administration of medicines will comply with Queensland Health policies, guidelines and standards (see QHEPS intranet site).
• Patient’s personal goals for medication will be integrated with evidence based clinical treatment guidelines.
• Strategies focused on medication adherence will be in place.
• Side effect monitoring will be routinely conducted with particular emphasis on metabolic complications of psychopharmacological treatment. Side effect monitoring will include a range of components:
  - psycho-education and information about mental health disorder/s or problems/s
  - ensuring there is a shared understanding of all aspects of the clinical risk management with explicit, documented evidence of the shared understanding in the clinical file
  - understanding the clinical care pathway within the mental health service.
• ACT will maintain effective links with Addiction services. Co-occurring alcohol and drug problems will be addressed in the recovery plan.
Where other services are involved in the care of the patient they will be included in the care planning process.

- ACT will support access to harm minimisation interventions and motivational interviewing.
- Carer support and education will assist with engagement, concordance with treatment regime, access and mental health literacy.

6. Team Approach

Key elements

- A multidisciplinary team approach is provided.
- Clear clinical and operational leadership will be provided for the team.
- Case coordination will be managed to ensure effective use of resources and to support staff to respond to crises in a timely, effective manner.
- Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision.

Comments

- The majority of patients will be known to the majority of team members
- The patient and family/carers will be informed of the multidisciplinary model.

7. Crisis Management

Key elements

- Crisis plans will be documented and supported for ACT patients as required.

Comments

- Crisis management plans will be developed in partnership with the patient and (where appropriate) their families and carers, and incorporated into the relapse prevention and recovery plan.
- Crisis management plans will also be developed in partnership with the mental health intervention coordinator and Queensland Police Service/Queensland Ambulance Service if indicated.
8. Continuity of Care

Key elements

• Clear information is provided for patients, carers and referral sources to contact the service (and other supports) across a 24 hour, 7 day period.
• The patient’s treating unit will be identified in the clinical record (CIMHA) and communication maintained throughout ACT service provision.
• Direct admission to an acute mental health inpatient unit should be facilitated by the ACT and the inpatient service if required, without the need to re-assess via the hospital ED.
• Each patient referred to the ACT following triage for ongoing assessment/intervention will be assigned a Principal Service Provider (PSP).
• If ongoing care is not required after initial assessment, the clinician who conducted the assessment will be responsible for effectively managing all associated communication. Documentation processes are to be completed within 24 hours. If referral to another clinical service is required, a follow-up communication by the PSP is required to ensure linkage is successful.
• Contact frequency will be dependent on individual patient need.

Comments

• Relevant information documents that are provided or accessible will include all relevant service response information.
• This will be documented in the clinical record.
• The process undertaken for sharing information will be explicitly documented for each case.
• Where possible, the clinician who conducted the initial assessment will be assigned as PSP.
• Capacity for increased frequency of contact (e.g. during crisis or the engagement period) needs to be accommodated by the team.

9. Transfer of Care
Key elements

- Effective communication and close support is required for all patients when transferred during a crisis.
- A timely written handover will be provided on every transfer occasion (See MSAMHS SHARE procedure).

Comments

- Guidelines for internal transfers are contained in MSAMHS Transfer of Care SHARE procedure (QHEPS intranet).

10. Onward Transfer of Care

Key elements

- Patients are transitioned promptly as clinically indicated.
- Transition planning will incorporate strategies for relapse prevention, crisis management and clearly articulated service re-entry processes.
- Comprehensive liaison and handover/handoff will occur with all other service providers who will contribute to ongoing care. Ongoing service providers will be involved in transition planning.

Comments

- The team will actively engage the patient in their transition planning from ACT at the time of first presentation.
- Transition planning will be a routine component of each clinical review process.
- All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within one week of discharge.
- Transition letters need to be comprehensive and indicate diagnosis, treatment provided, progress of care, recommendations for ongoing care and procedures for re-referral. Compliance with the standardised clinical documentation user guide is the minimum requirement for documentation.
- Relapse patterns, risk assessment and risk management information will be provided as clinically indicated.
- A follow up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the transition information was received.
and the service provider agrees to the provision of care.

• Where possible, family/carers will also be directly involved in transition planning.

• Where patients are lost to follow-up, there will be documented evidence of attempts to contact patient, family/carers and other service providers before transition from ACT.

11. Documentation, Data Collection

Key elements

• All patient clinical information will be entered into CIMHA and all contacts, clinical processes will be documented in CIMHA.

• All referred and open patients will have a designated PSP.

• All open patients will have a designated consultant psychiatrist.

• ACT will utilise routine outcome measures including Health of the Nation Outcome Scale (HoNOS), life skills profile (LSP) and the mental health inventory (MHI) as part of assessment, recovery planning and service development.

• Clinical records will be kept in accordance with legislative requirements.

• Local and statewide audit processes will monitor the quality of record keeping and documentation (including external communications) and support the relevant skill development.

Comments

• All clinical records are accessible through CIMHA. Personal and demographic details of the patient, their carer/s and other health service providers must be regularly reviewed and kept up-to-date on CIMHA.

• All progress notes are entered on CIMHA.

• The MHI is discussed with the patient on entry and exit from ACT services

• Routine outcome data is utilised, where clinically indicated at all formal case reviews and will be an item agenda on the relevant meeting agendas.

• Results of routine outcome data will be discussed with patients and their carers.
Routine outcome data is discussed with patients to record details of patients’ symptoms and functioning, monitor changes in symptoms and functioning.

12. Working with Families/Carers

Key elements

- Family/carers/significant others are involved in the mental health care as much as possible. Significant effort is made to support this involvement.
- The needs of families, carers and significant others must be routinely addressed.
- Support services will be offered to families and carers. Patient consent is not required to offer family and carers’ education and support.
- Children of parents with a mental illness will be routinely considered as part of all assessments, and interventions provided/facilitated if needed.

Comments

- Patient/guardian consent to disclose information and to involve family/carers in the care will be sought in every case.
- Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.
- Family and carers informed consent is also documented in the patient clinical record, detailing that they understand the treatment plan and agree to support the provision of ongoing care to the patient in the community.
- Identification of carers and their needs is part of the assessment process and is included in care planning.
- Support may be provided by a member of the mental health service organisation or another organisation.
13. Mental Health Peer Support

Key elements

- All patients will be offered information and assistance to access local peer support services.

Comments

- Peer support services may be provided by internal or external services.
- Patient consultants are accessible via RRPT.
Operational Elements

1. Related Services

ACT has developed comprehensive, clear guidelines and procedures with other parts of the MSAMHS, and with external service providers. This includes documented referral pathways and outlined service delivery responsibilities with respect to specific presentation types.

An integral role of the ACT is to demonstrate a thorough knowledge and understanding of the services available in their local area that support/provide health and mental health care. Relationships will be initiated and maintained with local service providers and support services. An up-to-date referral/resources database will be maintained by all ACT services.

Key internal service relationships include:

- 1300 MH CALL
- acute adult inpatient mental health teams
- community care teams
- child and youth community mental health teams
- older persons mental health teams
- homeless health outreach teams
- acute inpatient child and youth mental health teams
- mental health intervention coordinators
- primary care coordinators
- dual-diagnosis coordinators
- RRPT.

Effective relationships (and a working knowledge of the service they provide) must also be developed with other internal service providers
including (but not limited to):
• mobile intensive rehabilitation teams
• community care units
• consultation liaison mental health services
• transitional housing teams
• transcultural mental health
• forensic mental health services
• service integration coordinators
• perinatal and infant mental health services
• eating disorders service.

Key external (local) relationships include:
• Hospital ED.
• Emergency services (e.g. Queensland Police Service, Queensland Ambulance Service).
• Primary care provider (e.g. GPs, community health).
• Non-government organisations and other community support services.
• People and culture.

2. Clinical Governance
Each ACT service will have a designated team leader and consultant psychiatrist to provide governance within their delegation.
• Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.
• Within the team, the team leader will provide operational governance.
• The consultant psychiatrist will provide and be responsible for clinical governance.
• These position holders will establish a strong collaborative working relationship.

3. Hours
• ACT services will provide fully operational, multidisciplinary services on a seven day per week basis.
• The ACT will operate from 8am to 6pm.
• Crisis assessments presenting outside of business hours will generally be conducted at a hospital ED by MHCALL.
• Routine assessments and interventions will generally be scheduled during business hours (seven days per week).

4. Training
Staff will be provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to ensure that they are clinically competent. All training will be based on best practice principles, evidence-based treatment guidelines and underpinned by the Queensland Government Recovery Framework.

The ACT will have dedicated clinical education and clinical supervision time and resources, in addition to clinical staffing numbers.

Education and training will include a focus on strategies and mechanisms to foster meaningful patient and carer participation across all levels of service delivery, implementation and evaluation. Patients and carers need to be involved in the development and the delivery of staff training.

Education and training should include (but will not be limited to):
• recovery education and training
• mental health triage training
• risk assessment and management and associated planning and intervention
• de-escalation training
• aggression behaviour management
• solution focussed brief therapy
• positive symptom management
• Mental Health Act 2000
• evidence-based practice in service delivery
• responding to psychiatric emergencies
• alcohol and drug assessment and interventions
• detection and management of co-occurring alcohol and drug problems
• motivational interviewing
• clinical and operational skills/knowledge development (including mental health generic and discipline-specific training needs).
• change management training
• medication and side effect management
• patient focussed care planning
• routine outcome measurement training
• cultural capability training.
In-house training/education will reflect best practice that meets local demands, challenges and needs, with consideration given to further improving skills and knowledge in team work, case formulation, communication, record keeping and the local model of service.
Teams are encouraged to make the relevant components of their training available to their service partners (e.g. NGOs, GPs).
Summary

There is an explicit understanding that staff will optimise their skills to delivering effective and efficient recovery-focused patient-oriented care. Staff out of necessity shall:

• have the attitude that patients can and do recover from mental illness
• actively support the principle that ‘every door is the right door’
• actively support the acquisition of skills, with senior level clinical expertise and knowledge being demonstrated by the majority of staff
• senior staff, including medical staff, will take an active role in fostering the development of clinical skills in newer staff
• actively support strong internal and external partnerships
• demonstrate clear and strong clinical and operational capabilities fitting their roles, and work collaboratively
• assertively regularly review and manage their caseload
• actively pursue and engage in professional support, clinical supervision and training
• engage patients, their family/carers and other service providers in all aspects of care
• ensure their team is well integrated with local mental health services, EDs and primary care supports.