POLICY TITLE:	**Assessment, Diagnosis & Treatment**
Policy Number:	H04
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Date of Issue:	15/08/2023
Date of Review:	15/08/2026
Policy Owner:	Kris Irons, Specialist Director
Ratified by:	Paul Cowans, Specialist Director
Responsible signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • aims to ensure that patients are assured that their needs will be assessed on admission and regularly thereafter and that treatment and care will be provided to meet those needs.
Cross Reference:	H11 Informed Consent H34 Care Programme Approach H62 Healthcare Records OP05 Mental Capacity

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

ASSESSMENT, DIAGNOSIS AND TREATMENT

CONTENTS

1 SCOPE

1.1 This policy applies to all sites and services across England, Scotland and Wales. Where there are differences between nations, this will be clearly highlighted.

2 ASSESSMENT

2.1 Each Priory Healthcare site will have a clearly defined range of treatments and facilities available on site.

2.1 Priory Healthcare sites will not accept patients for admission if they cannot provide the specific and appropriate treatment and care.

2.3 On arrival the patient should be greeted and engaged by staff in a warm, empathic, respectful and professional manner, anticipating possible distress.

2.4 The formal assessment and admission process should commence within one hour of arriving for admission and patients must have a member of staff with them until the admission assessment is complete.

2.5 Before the assessment begins, the health professional undertaking the assessment should ensure that the patient understands:

(a) The purpose of the assessment and how long it will last
(b) That the assessment will cover key aspects of their experiences and life
(c) Confidentiality and data protection as this applies to them
(d) The basic approach of shared decision making
(e) That although they can be accompanied by a family member, carer or advocate for all or part of the time, it is preferable to see the person alone for some of the assessment
(f) That they can refuse permission for any other member of staff, such as a student to be present.

2.6 When carrying out an assessment:

(a) Ensure there is enough time for the patient to describe and discuss their problems
(b) Allow enough time towards the end of the appointment for summarising the conclusions of the assessment and for discussion, with questions and answers
(c) Explain the use and meaning of any clinical terms used
(d) Explain and give written/pictorial material in accessible format about any diagnosis given.
(e) Give information about different treatment options, including drug and psychological treatments, and their side effects, to promote discussion and shared understanding
(f) Offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed'

(Patient experience in adult mental health services pathway, NICE 2014).

2.7 The holistic assessment should cover psychological, psychiatric, physical and social functioning, risk to the individual and others, any needs arising from co-morbidity and personal circumstances including relationships, cultural, housing, financial and occupational status.

2.8 Views of the patient must be taken into account as should the views of families/carers. Consent to liaise with families and carers should be sought from the patient. If the patient does not consent for any contact with families/carers, information and views can still be obtained from this source.

2.9 All staff must comply with local procedures for assessment and admission.

3 DIAGNOSIS

3.1 All staff attending to the diagnosis, treatment and care of patients are to be trained and/or experienced in the relevant clinical care e.g. of children and adolescents.

3.2 An initial diagnosis will be given by the admitting Doctor and recorded on the patient's health record in the electronic patient record (CareNotes). Diagnosis will be regularly reviewed by the Consultant Psychiatrist and a final ICD10 diagnosis code entered on the patient's clinical record on discharge.

4 CARE AND TREATMENT

4.1 The approach to individuals' care and treatment should put them at the centre of the process and promote social inclusion and recovery. It should be respectful - building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It should recognise the individual as a person first and person who accesses service second (*Department of Health 2004, Ten Essential Shared Capabilities - A Framework for the Whole MH Workforce).*

4.2 Treatment should follow the recommended and approved procedural clinical guidelines or care pathway for the specific diagnosis. All staff providing the treatment and care will be made aware of the clinical guidelines or care pathways and will be advised of any new or updated changes being introduced. Training will be provided if necessary.

4.3 Following assessment, individual therapy programmes and care plans should be formulated, clearly documented and added to the patient's clinical record. The care plan for therapy should include the treatment and care objectives of the therapy and the anticipated outcomes. All therapy programmes and care plans should be aligned and tailored to meet the needs of individual patients. Plans should not contain jargon and should be written so that the patient can understand them. The patient should be helped to identify and prioritise their personal goals for recovery, encouraging self-management of mental health problems and/or disability (by providing information, reinforcing existing coping strategies or teaching new skills, etc.).

4.4 Any physical healthcare needs identified as part of the assessment should have a corresponding care plan, outlining what the patient and staff need to do to manage the condition.

4.5 Where patients are known to use behaviours which may challenge staff such as self-harm or aggression, staff should work with the patient to develop a support plan. This will include the function of the challenging behaviour; what the triggers to the behaviour are; what warning signs there are; what helps the patient at these times and clear guidelines for staff to use if the behaviour reaches the point where the patient puts his or herself at risk of harm.

4.6 Patient consent will be documented in accordance with policies H11 Consent and OP05 Mental Capacity.

4.7 The Care Plan will be regularly reviewed in collaboration with the patient and the Multidisciplinary Team (MDT), and in conjunction with the Care Programme Approach (CPA) (see H34 Care Programme Approach-Care Treatment Planning) and any changes in objectives or treatment will be clearly documented.

5 REFERENCES

5.1 CQC (2015) Specialist Mental Health Services: Provider handbook
DH (2004) Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce
DH (2011) No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages
DH (2014) Positive and Proactive Care: Reducing the need for restrictive interventions
NICE (2014) Service user experience in adult mental health services pathway
NMC (2015) The Code: Professional standards of practice and behaviour for nurses and midwives
Mental Health (Care and Treatment) (Scotland) Act 2003.

6 ASSOCIATED FORMS

6.1 **MDT reviews are now documented on the MDT form in carenotes**
H(RR) Form: 06 - CPA Review Meeting (Rehabilitation & Recovery)
H(RR) Form: 06A - CTP Review Meeting (Rehabilitation & Recovery)
H(RR) Form: 06B - My CPA/CTP Report (Rehabilitation & Recovery Patient Questionnaire)
H(RR) Form: 06C - Family and Carers Questionnaire for CPA/CTP Meeting (Rehabilitation & Recovery)
H Form: 10A - CPA Report (Adolescent Services)
H Form: 10B - CPA Report (Adult Acute Services)
H Form: 10C - CPA Report (Eating Disorder Units)
H Form: 10D - CPA Report (Forensic Services)
H Form: 10L - CPA Report (BIS Services)
OP Form: 65 - Mental Capacity Assessment

7 EQUALITY IMPACT ASSESSMENT

7.1

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 2021)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None		
Disability	None		
Gender re-assignment	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:	None		
EIA completed by:			
Name: **Role/Job Title:**	Kris Irons, Specialist Director		
Date completed:	03/08/2023		