South Essex Partnership NHS
NHS Trust

8203

CPA

Handbook for Practitioners

This document has been produced
by the CPA Steering Group

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Contents

Background

The Care Programme Approach was introduced by the Department of Health in 1991 to provide a framework for effective mental health care. The framework was further updated in 1999 with the publication *'Effective Care Co-Ordination in Mental Health Services: Modernising the Care Programme Approach'.*

The Care Programme Approach is applicable to all adults of working age in contact with mental health services, and the principles of CPA should be applied when dealing with younger and older people with mental health problems.

It has four main elements:

- ☐ Systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services.
- ☐ The formation of a care plan which identifies the health and social care required from a variety of providers.
- ☐ The appointment of a Care Co-Ordinator to keep in close touch with the service user and to monitor and co-ordinate the care plan; and
- ☐ Regular review and, where necessary, to agree changes to the care plan.

Purpose of this handbook

This handbook has been so designed to assist practitioners in understanding the principles of the Care Programme Approach and to act as a guide in following the standards and processes to be adhered to.

For details in completing the CPA documentation please refer to the CPA flowcharts listed below, which are attached in the appendix of this booklet.

- ☐ Overview of CPA
- ☐ Assessment and Care Planning under CPA
- ☐ Risk Assessment & the Management of Risk under CPA
- ☐ Carers assessment under CPA
- ☐ Review and closure / transfer under CPA.

Criteria for acceptance for CPA

The Care Programme Approach applies to people with a severe mental illness as defined within the document Building Bridges published in 1995.

The guidance advises that the person should meet one or more of the following:

- ☐ Diagnosed as suffering from a form of mental illness (typically, people suffering from schizophrenia or a severe affective disorder, but including dementia).
- ☐ Suffers substantial disability or severe social dysfunction as a result of their mental illness, such as an inability to care for themselves independently, sustain relationships or work, or their essential support network is at immediate risk of breaking down which will result in depriving them of their right to live in the community.

a) Currently displaying florid symptoms; or

b) Suffering from a chronic, enduring condition.

- ☐ Have suffered recurring mental health crisis, leading to frequent admissions / interventions.
- ☐ On occasions is a significant risk to their own safety or that of others.

Not all these conditions need to be met for a person to be regarded as seriously mentally ill. For example:

- ☐ A person who has a chronic mental illness, but who has not been in regular contact with the services would be regarded as having a serious mental illness;
- ☐ An individual who presents for the first time with florid symptoms should be assessed to ascertain if they are suffering from a serious mental illness;
- ☐ A person with a very serious phobic disorder which was necessary chronic, but resulted in very considerable disabilities or social dysfunctioning would also fall into this remit.
- ☐ A person can be seriously mentally ill without occasioning significant risk to their own safety or that of others.

Levels of need

The Care Programme Approach is delivered according to two levels of need:

☐ **Standard CPA**

The characteristics of people on Standard CPA will include some of the following:

- They require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline
- They are more able to self manage their mental health problems
- They have an active informal support network
- They pose little danger to themselves or others
- They are more likely to maintain appropriate contact with services.

Those on Standard CPA will have a Care Co-Ordinator from any discipline, including medical staff, e.g., Consultant Psychiatrist. The Care Co-Ordinator will be the person who provides the bulk of the service user's care plan.

☐ **Enhanced**

People on Enhanced CPA are likely to have some of the following characteristics:

- They have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination
- They are only willing to co-operate with one professional or agency but they have multiple care needs
- They may be in contact with a number of agencies
- The individual may be at risk or present a risk to others.

Those on Enhanced CPA will have a Care Co-Ordinator from the following disciplines:

- Community Psychiatric Nurse
- Approved Social Worker
- Social Worker
- Occupational Therapist.

The Consultant Psychiatrist is clinically responsible for the medical care for the person with mental health problems and is designated as the responsible medical officer (RMO).

The Consultant will ensure that the identified mental health care needs are fully met within the care plan and addition will be involved in discussion and decision making on the following:

- The level of CPA required – Standard or Enhanced
- The assessment and management of risk
- Discharge of the service user from CPA back to the care of his/her GP.

Assessment

The purpose of undertaking an initial assessment / screening of a service user circumstances is to determine whether intervention from the mental health services is considered appropriate.

Where the criteria for the Care Programme Approach is met. A full holistic health and social care assessment must be undertaken to determine the following:

- Areas of need / difficulties, including level of risk
- Strengths and abilities of the service user
- Identify the service users CPA level of need, e.g., Standard or Enhanced
- Identify the need for specialist assessments.

The assessment process must be through and comprehensive and the practitioner undertaking the assessment must ensure that the service user and carer, where appropriate are central to the process.

Key areas to be assessed including prompts have been included in the full CPA assessment documentation.

The assessment must take into account the service users cultural, gender and religious needs.

The undertaking of a holistic health and social care assessment is viewed as an essential phase of the Care Programme Approach, upon which the Care Plan, including the Contingency & Crisis Plan is based.

Risk Assessment and the Management of Risk

Risk assessment is an essential and ongoing part of the CPA process. Risk must be clearly documented and reviewed regularly. Risk management is regarded as ongoing process.

Risk includes:

- ☐ **Self harm**, including accidental harm at home / outside the home, alcohol, drug or substance abuse, deliberate self-harm
- ☐ **Suicide**, including previous attempts, threats, opportunity, means
- ☐ **Violence to others**, including access to potential victims, specific threats made, history of violence to family, staff, to other service users, the general public, specific other people, degree of physical harm caused, history of sexual assault, risk to children (non-accidental)
- ☐ **Other types of risk** to other people, including risk to children (accidental), arson, risk to staff other than violence, destruction of property
- ☐ **Self neglect**, including inability to care for self, lack of carer support
- ☐ **Exploitation by others/vulnerability to abuse** such as financial, sexual, physical.

The Risk Profile Tool

The Risk Profile Tool is to be completed in the following circumstances:

- ☐ For those clients who meet the criteria for *'Enhanced'* CPA status
- ☐ On admission to hospital and / or prior to discharge from hospital
- ☐ At the practitioners discretion; If in doubt, complete the risk profile.

The completion of the Risk Profile Tool will supplement the CPA Contingency Plan.

The Key Events Recording Sheet

The purpose of the *'Key Events'* recording sheet is to enable current and future professional staff involved with the management of a service users care plan the opportunity to scan the key historical episodes in a service users care career at a glance, without the need to read through copious volumes of case notes. Therefore assisting in the assessment and management of risk.

Provision of Crisis Cards

The provision of a *'Crisis Card'* for those on Enhanced CPA, providing advise upon how s/he should be helped in a crisis / emergency is viewed as good practice.

Role of the Care Co-Ordinator

The Care Co-Ordinator has:

- ☐ Responsibility for co-ordinating the care, keeping in touch with the service user, ensuring that the care plan is delivered and ensuring that the plan is reviewed as required.

The role is essentially one of co-ordination and communication; assessment and care planning.

In meeting the above, the Care Co-Ordinator will be required to undertake the following:

- A systematic assessment of the person's health and social care needs, including an assessment of risk and any specialist assessments
- Co-Ordinate further specialist assessments where necessary
- Determine the person's CPA level, in consultation with others
- Co-Ordinate the formulation and updating of the care plan, ensuring that all those involved understand their responsibilities and agree to them
- The care plan is sent to all concerned
- The provision of a crisis and contingency plan, regularly updated and circulated
- Maintain regular contact with the service user and monitor their progress, whether at home or in hospital
- To make sure the right services are in place in the right quantities at the right time
- If a service user who remains vulnerable refuses to take part in the CPA process, all steps should be undertaken to find out why, and continue to attempt to engage them

- Ensure that the person is registered with a GP and that s/he is involved and informed as necessary
- Organise and ensure that reviews of care take place, and that all those involved in the service user's care are told about them, consulted, and informed of any outcomes
- Ensures the person understands the Care Co-Ordinator role, knows how to make contact and who to contact in the Care Co-Ordinators absence
- Provision of assistance with housing; education; employment and leisure
- Purchase of services where appropriate
- The Care Co-Ordinator may also be required take on other roles such as Guardian under Section 7 of the Mental Health Act 1983 / Supervisor under Section 37, 47 or 48 of the Mental Health Act 1983 and / or the Mental Health (Patients in the Community) Act 1995.

Care Planning

A care plan is a record of needs, actions and responsibilities written in a jargon free way.

Care plans exist for the benefit of the person using the service, and they should be based around their needs, not around the ability of the service to provide.

Devising a care plan is part of the process of understanding a person's situation and deciding a way forward. Its main purpose is to:

- Summarise identified needs / difficulties and how they are to be met; and
- It is a formal record setting out what is going to be done, why, when, and by whom.

Care Planning:

- Is based on a thorough assessment of an individual's health and social care needs
- Must focus on a service user's strengths and seek to promote their recovery
- Must recognise the diverse needs of service users, reflecting their cultural and ethnic background as well as their gender and sexuality
- Take into account any risk to the person, their carer, any worker involved in delivering the care plan and the wider community.

Care plans are more relevant if they involve the person in agreeing and writing the care plan as much as possible.

The written care plan should be drawn up by the Care Co-Ordinator, with the involvement of the service user, and where appropriate their carer.

A copy of the care plan must, where appropriate be given to the service user, his/her GP and others involved.

It is essential that practitioners maximise the extent to which the client knows and understands their care plan, and agrees with it. The practitioner must record evidence of this.

Care plans must be expressed in terms of needs of the client rather than resources. The Care Plan is about interventions; resources and actions to meet identified needs / difficulties.

Purchase of Social Care Services

The NHS and Community Care Act 1990, gave Local Authorities the lead responsibility for assessment and care management of those people with social care needs. With introduction of the Care Programme Approach, it has been agreed that CPA is now the lead process for assessing need, care planning and co-ordination of care for those people with enduring mental health difficulties for all agencies.

Where services need to be purchased in order to a meet an identified need and where they relate to social care. The Care Co-Ordinator regardless of their discipline should refer to the Care Management Purchasing procedures for each Local Authority.

The In-Reach Principle / Integrated Care Pathway

CPA must not be considered simply as a framework for aftercare following discharge from hospital. CPA provides a framework for care where-ever service users are in the system, including residential care and prison as well as community settings.

The development of assertive in reach approaches into prisons, as well as in-patient settings, are viewed as essential.

For in-patient settings, the following should be followed:

- ☐ The Care Co-Ordinator retains the responsibility of a Care Co-Ordinator during the service users period of admission
- ☐ Ward Staff to inform the local CMHT of new admissions by fax on the day of admission
- ☐ If the patient is known to the CMHT and has an existing Care Co-Ordinator. The CMHT to inform and forward a copy of the assessment / care plan / risk documentation to the ward by fax
- ☐ The Care Co-Ordinator to liaise with the named nurse / RMO at the earliest opportunity for the purpose of maintaining contact with the patient and to agree / support the treatment programme
- ☐ Named nurse / ward to inform the CMHT of patients sent on leave. For planned leave, the Care Co-Ordinator should be involved in the decision and be informed by fax / telephone when leave happens
- ☐ All service users who are initially accepted into the service through admission into acute in-patient services will be allocated a named nurse or link worker within 24 hours of admission. His / her responsibilities will include the service users care during the in-patient episode of care and for liaising with community services

- ☐ For a new in-patient, the appointment of a Care Co-Ordinator will come from the team that provides services to the locality in which the patient normally resides. On identifying the need for on-going support for the patient upon discharge. The named nurse will complete the referral and screening forms to the appropriate team at the earliest opportunity, preferably within seven days of their admission onto the ward
- ☐ The Care Co-Ordinator will be responsible for completing a holistic assessment, comprising of both health and social care needs, for the purpose of compiling a robust care plan, prior to discharge. In the case of an a client who is already subject to CPA and has a care plan, a review of the care plan; crisis and contingency plan is required well in advance of their discharge from the ward
- ☐ A copy of the care plan must be given to the patient prior to discharge
- ☐ Severely mentally ill people on Enhanced CPA discharged from hospital must be seen by their Care Co-Ordinator within one week following discharge
- ☐ After discharge from hospital the implementation of the care plan must be reviewed within a one month period
- ☐ Care plans for service users with severe mental illness who are at high risk of suicide must include more intensive provision after discharge from in-patient care for the first three months.

Transfer of Care Co-Ordination responsibilities under CPA

To ensure the smooth transfer of Care Co-Ordination responsibilities under CPA from one team / service to another, including transfer of CPA responsibilities to another Trust. The following standards must be followed:

- ☐ For those clients subject to Enhanced CPA. A joint handover meeting between the referring team and the receiving team must be arranged to review the care plan; crisis and contingency plan
- ☐ It is viewed good practice that where a service user is transferred to another team, this is only undertaken after a 3 month period of relative stability.

The principles of transferring Care Co-Ordination responsibilities are as CPA reviews.

CPA Reviews

The purpose of a review is to consider:

- ☐ Any progress the service user has made
- ☐ The views of the service user, carer, other professionals
- ☐ How the service user has responded to the services being provided
- ☐ Ways in which their needs may have changed, and as a result
- ☐ The extent to which the care plan requires amending
- ☐ Ensure services are appropriate and non stigmatising
- ☐ To consider discharge or transfer of CPA.

The regularity of the review will depend on the needs of the individual. The format of the review will also depend on the amount of support being offered, although the review should be planned in advance. Any member of the care plan, including the service user or carer can ask for a review to be held.

It is particularly important to review the implementation of the care plan within the first month of discharge from hospital.

The review meeting is ideally chaired by the Care Co-Ordinator and should include key persons such as client, carer, Consultant Psychiatrist, GP, etc.

The level of complexity of each case will determine who needs to be present at the CPA review. For those on Standard CPA, the Care Co-Ordinator and the service user may carry out the review alone.

For those on Enhanced CPA where it is not practical to have all those individuals involved in the care plan to attend a meeting. The Care Co-Ordinator should ensure the views of others are represented, e.g., the GP could be contacted by either letter or telephone to be asked for their contribution.

Outcome of the review may include:

- ☐ Change to the amount of support required
- ☐ Change in the level of CPA
- ☐ Discharge from CPA or transfer of Care Co-Ordination responsibilities to another team or service
- ☐ Updating the risk assessment, crisis, or contingency plan.

At each review the date of the next CPA review must be set and the service user informed, including all parties involved in the care plan.

Copies of the CPA review documentation must be circulated to all those involved in the care plan, including the service user and where appropriate the carer(s).

Carer's Assessment under CPA

Carers of people with who provide regular and substantial care for a person on CPA have a right under the 'The Carers (Recognition and Services) Act 1995; The Carers and Disabled Children Act 2000, including the National Service Framework for Mental Health' to have an assessment of their caring, physical and mental health needs and ability to continue to care.

A carer may be a relative, friend or neighbour, and may be a sole carer or part of a wide caring network. Any carer providing regular and substantial care to a person who is subject to the Care Programme Approach must be offered an assessment of their needs in relation to their role as a carer.

The assessment should include:

- ☐ Current support provided by the carer or others for the user
- ☐ Current support for the carer
- ☐ Carer's views
- ☐ Carer's needs / difficulties including: financial / benefits advice; domestic or personal assistance; respite; emotional support; accommodation; social and recreational; employment; health; advocacy; transport and information about the mental health needs of the service user.

The Carer's Support Plan should include:

- ☐ Information about the mental health needs of the person for whom they are caring, including information about medication and any side effects
- ☐ Provision of advise on how to cope at critical times
- ☐ How to recognise signs of a relapse and information on what to do and who to contact in a crisis
- ☐ What will be provided to meet their own mental and physical health needs, and how it will be provided
- ☐ How to get information and advise on income, housing, educational and employment matters
- ☐ Arrangements for social support, including access to carer's support groups
- ☐ Arrangements to enable a break from caring.

Information Sharing and Confidentiality

Sharing information about an individual between partner agencies is vital to the provision of co-ordinated and seamless care to that individual. This in turn will cement partnership working, aid the efficient delivery of care, and, based on informed consent, increase service users' confidence that care is truly co-ordinated.

- ☐ Consent to share information should be sought at the earliest opportunity
- ☐ All service users should be informed about what information will be shared with other agencies concerned with their well being
- ☐ All service users should be made aware of the circumstances in which staff will have a duty to disclose information in the public interest. Confidentiality may be overruled in the following circumstances:
  - Where the need to protect the service user from others, or others from the service user, or the service user from him/herself, outweighs the duty of confidence to the service user
  - Where the service user is incapable of making a decision to his/her mental state
  - Where the disclosure of information is ordered by a Judge
  - Disclosing information relating to firearms to the police
  - Where a crime has been committed
  - Where there is an issue of risk to a child, the welfare of the child is paramount and over-rides any apparently conflicting needs of parent, including confidentiality.

Information should only be provided on a need to know basis, and restricted to that information in which the recipient has a legitimate interest. This will require taking information from the CPA documentation and writing a brief report for others.

Caseload Management and Clinical Supervision

Good caseload management and the provision of clinical supervision is viewed as critical to maintaining effective practice.

It is the responsibility of the Manager and / or Clinical Leader to ensure, and be able to demonstrate, that staff undertaking Care Co-Ordinator responsibilities are maintaining caseloads of suitable sizes with services users who have active needs, and that support and clinical supervision is provided.

Best practice advises of the use of a validated tool taking into account the following:

- Level of Care Co-Ordination
- Management of risk
- Frequency of contact with client
- Other responsibilities the practitioner may have.

Clinical Supervision

Clinical supervision is viewed as an essential requirement in accordance with both the Partnership Trust and the Local Authority Policies.

Family Group Conference for Mental Health

Family group conference (FGC) is based on the belief, that service users and families are the people who know most about their difficulties including more than any professional.

FGC for mental health helps the Care Co-Ordinator to build upon existing family, friendship and community networks to provide alongside the CPA process structured and facilitated support to people with mental health problems.

FGC for mental health has proved very effective in enabling families to communicate and co-operate in ways not possible before, resulting in family plans in the majority of cases. Family plans include advance agreements, co-ordinating the responsibilities of individual family members in the event of a crisis. In this way FGC has effectively tackled problems of social or emotional isolation by connecting the service user back into the family network. In addition family members are able to recognise early warning signs or when the service user might be relapsing.

FGC should be considered as part of a CPA where a client is part of a family network. For further details contact your Local Authority guidance or alternatively the Brentwood Community Mental Health Team.

Direct Payments and Mental Health

The Community Care (Direct Payments) Act 1996 provides a legal right for disabled people to receive a payment from the Local Authority community care monies, to enable them to purchase their own care based on an agreed needs led assessment.

Direct Payments is open to people with a physical / sensory disability, learning disability; HIV / Aids or an enduring mental health problem and have been assessed as needing community care services.

Everyone to whom Direct Payments are made, has, by law, to be considered 'willing and able' to manage them, with assistance if necessary. This means that they must be able to direct the both the services they receive and the administration of them. People who receive a Direct Payment are accountable for the way the money is spent.

The aim of a Direct Payment is to give more flexibility in how services are provided. By giving individuals money in lieu of social care services, people will have a greater choice and control over their lives, and are able to make their own decisions about how their care is delivered.

This Government is concerned to increase the number of people who receive direct payments and to ensure that all people from all client groups, including people with enduring mental health difficulties have access to the choice that Direct Payments bring.

For further details please refer to your Local Authority guidelines for Direct Payments.

ADVOCACY

Advocacy is speaking up on behalf of another person to secure rights, meet needs or support people to make informed choices. Advocacy makes sure a persons voice is heard, that there needs are met and that they get the services they want and need, that they know there rights and have information to make informed choices.

Information about advocacy services should be given to users soon after referral / admission into hospital / registration onto CPA.

Advocates, whether paid or unpaid, have a role in representing users or helping them to represent themselves. They should be encouraged to be involved in CPA if users request and / or need them.

Advocacy involvement may include attendance at Care Planning meetings, assistance to users in making statements of their needs and in agreeing Care Plans, and attendance at CPA Reviews.

References

Joint Health and Social Services Circular: The Care programme Approach for people with a mental illness, referred to specialist psychiatric services. HC(90)23/LASSL(90)11 DoH (1990)

Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. DoH (1995)

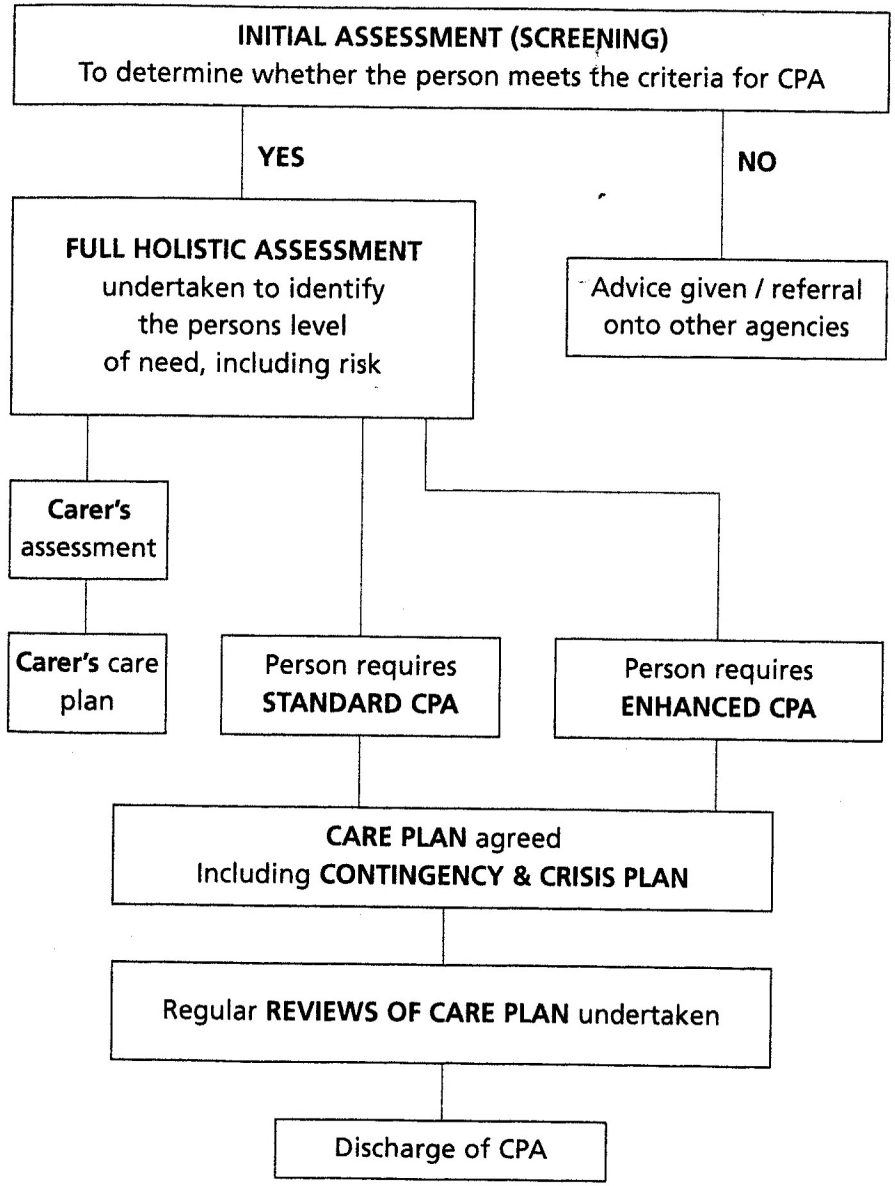
National Service Framework for Mental Health.
DoH HSC1999/223:LAC(99)34 30.9.99

Effective Care Co-Ordination in Mental Health Services: Modernising the Care Programme Approach. NHSE October 1999

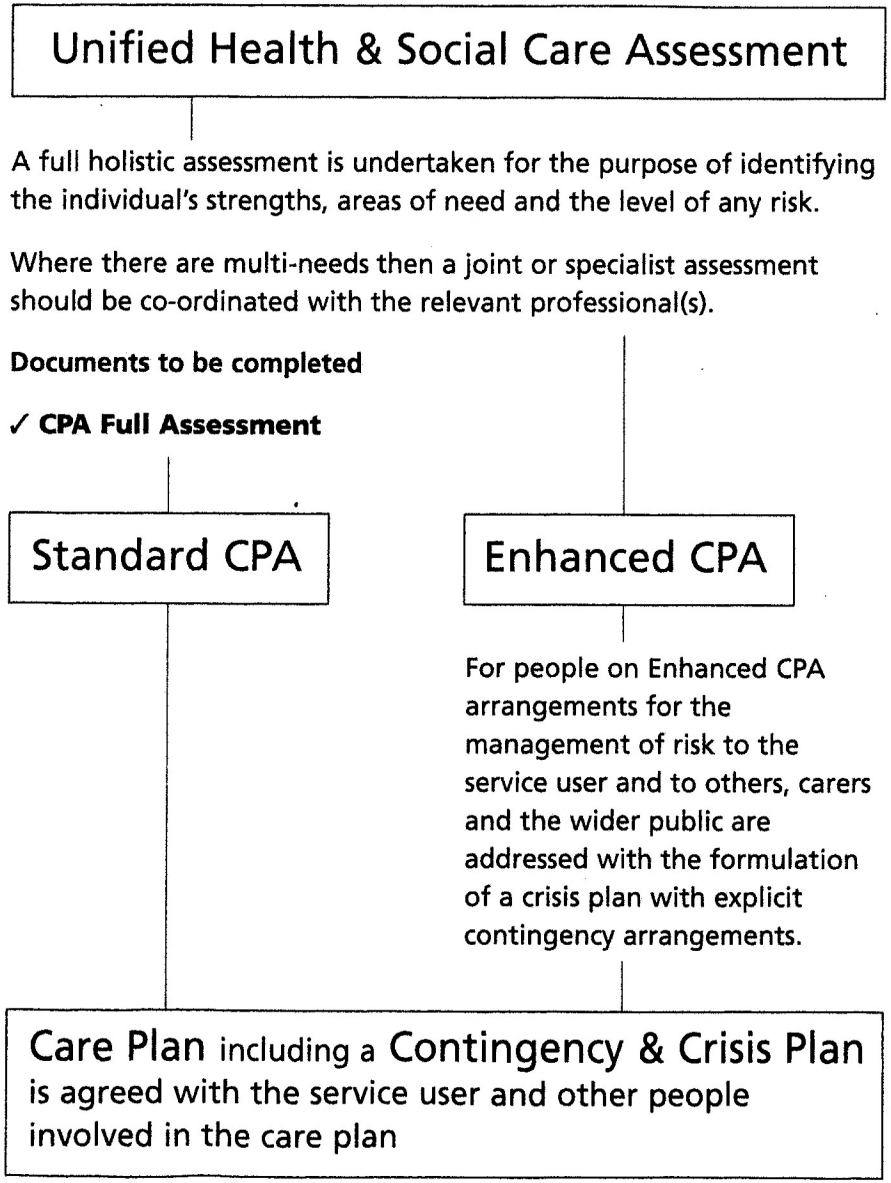
Carers (Recognition and Services) Act 1995 Policy Guidance and Practice Guide. DoH LAC(96)7 HSG(96)8 28.2.96

Appendix

1. Overview of CPA



2. Assessment of Care Planning under CPA



Care Plans are more relevant if they involve the person in agreeing and writing the care plan as much as possible.

A copy should be given to the service user, his or her GP and others involved with a date agreed and recorded for when the care plan is to be reviewed.

Documents to be completed

- ✓ **Registration**
- ✓ **Care Plan**
- ✓ **Contingency & Crisis Plan**
- ✓ **For those on Enhanced CPA – Risk Profile**
- ✓ **Consent for information on mental health**

3. Risk Assessment and the Management of Risk under CPA

Risk assessment is an essential and ongoing part of the CPA process. Risk must be clearly documented and reviewed regularly.

Risk includes:

- **Self harm**, including accidental harm at home / outside the home, alcohol, drug or substance abuse, deliberate self-harm
- **Suicide**, including previous attempts, threats, opportunity, means
- **Violence to others**, including access to potential victims, specific threats made, history of violence to family, staff, to other service users, the general public, specific other people, degree of physical harm caused, history of sexual assault, risk to children (non-accidental)
- **Other types of risk** to other people, including risk to children (accidental), arson, risk to staff other than violence, destruction of property
- **Self neglect**, including inability to care for self, lack of carer support, exploitation by others and vulnerability to abuse such as financial, sexual, physical.

Risk Profile Tool

The Risk Profile Tool is to be completed in the following circumstances:

- For those clients who meet the criteria for *'Enhanced'* CPA status
- On admission to hospital and / or prior to discharge from hospital
- At the practitioners discretion.

The completion of the Risk Profile Tool will supplement the CPA Contingency Plan.

Key Events Recording

The purpose of the *'Key Events'* recording sheet is to enable current and future professional staff involved with the management of a service user's care plan the opportunity to scan the key historical episodes in a service users care career at a glance, without the need to read through copious volumes of case notes. Therefore assisting in the assessment and management of risk.

4. Carers Assessment under CPA

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A carer may be a relative, friend or neighbour, and may be a sole carer or part of a wide caring network. Any carer providing regular and substantial care to a person who is subject to the Care Programme Approach should be offered an assessment of their needs in relation to their role as a carer.

Carers Assessment

The National Service Framework for Mental Health standard six called *'Caring about Carers'* advises *'Carers often make a major and valued contribution to the support received by many people with a mental illness being treated in the community. Where a care programme depends on such a contribution, it should be agreed in advance with the carer who should be properly advised both about such aspects of the patient's condition as is necessary for the support to be given, and how to secure professional advice and support, both in emergencies and on a day-to-day basis'.*

Carers Support Plan

The information from the assessment is put together into a Carers Support Plan for the carer. A Carer's assessment should be repeated on at least an annual basis.

Documents to be completed

✓ **Carers assessment**

✓ **Carers Support Plan**

5. Review and Closure / Transfer under CPA

CPA Review Arrangements

The purpose of a review is to consider

- Any progress the service user has made
- The views of the service user, carer, other professionals
- How the service user has responded to the services being provided
- Ways in which their needs may have changed; and as a result
- The extent to which the care plan requires amending.

The regularity of the review will depend on the needs of the individual. The format of the review will depend on the amount of support being offered, although the review should be planned in advance. Any member of the care plan, including the service user or carer should be able to ask for a review to be held.

To assist the service user in preparing for their CPA review, the FACE *'How are You'* questionnaire should be forwarded one week prior to the review.

CPA Review Held

Outcome of the review may include:

- Change to the amount of support required
- Change in the level of CPA
- Discharge / transfer
- Update the risk assessment, crisis, or contingency plan

Documents to be completed

✓ Review

CPA Care Plan / Contingency Plan amended

Discharge / Transfer

CPA should only be discontinued following a review. Where a service user is subject to a care plan under Section 117 of the MHA 83. This can only be discharged with the agreement of the two agencies that such services are no longer required. For transfer of CPA responsibilities for enhanced CPA, the Care Co-ordinator should as soon as possible arrange a planning meeting between the referring and the receiving unit.

Documents to be completed

✓ Discharge / Transfer

CPA Standards

1 CPA Care Plans must include specific follow up in the first week following discharge from hospital.

2 CPA Care Plans must have a record of where, when and by whom services will be delivered, intended outcome and timescales.

3 Care Plans should be signed by the client.

4 All Care Plans must have a review date.

5 Following discharge from hospital, a CPA review must be held within 4 weeks.

6 Crisis Plans must make an individualised record in each of these areas:

   a) Things that are likely to trigger a crisis

   b) Signs that the client is becoming unwell

   c) Particular difficulties that have arisen in the past

   d) Who the client is most responsive to

   e) How to contact that person

   f) Previous strategies which have been successful in overcoming crises.

7 All clients must be given a Crisis Card when accepted for CPA or on discharge from hospital.

8 A Carers Assessment must be offered to anyone living with, or caring for, a client on CPA.

9 All clients will be invited to complete a CUES assessment prior to a CPA review.

10 Care Plans must be revised and re-issued after a CPA review.