**CYP IAPT In Patient Training**

**Care and Transition Self-Assessment Document**

The purpose of this document is to provide a framework for units to benchmark how effectively their system and services are engaged within the involvement of young people and their families within the care planning and discharge process. The aim is that this document can be used as an assessment to support action and implementation plans, and has been developed to enable baseline and subsequent follow-up measurement in implementing and maintaining effective transitions for young people. Consideration of the five components parts is indicated in the diagram below:

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| No | Component | Where are we? | | Next Steps needed | |
| 1.0 | **Involving children and young people in planning** |  |  | | |
| 1.1 | What information do CYP and their families need about their health and care:  Information leaflets, treatment options  Access to health records |  |  | | |
| 1.2 | Patient Decision aids: What support is available to CYP and their families to make choices, interpret information or consider what is important to them? |  |  | | |
| 1.3 | Communication Methods: Do CYP need any additional support, literacy, communication aids? |  |  | | |
| 1.4 | Is there any information you would like to collect from CYP and their families prior to the care planning discussion?  Howe will you collect this information? |  |  | | |
|  | **Involve their parents, carers and any staff who support them** | | | | |
| 1.5 | How is the family’s knowledge and expertise collated in the assessment process? |  |  | |  |
| 1.6 | How and when is the use of independent advocacy services communicated to the young person and their family? |  |  | |  |
| 1.7 | How does the young person and their family know about the unit?  Visit/ video clip/ leaflet etc |  |  | |  |
| 1.8 | Can you identify which professional are involved in the YP’s care? |  |  | |  |
| 1.9 | How is information being shared between these professionals/ services? |  |  | |  |
| 1.10 | Do other professionals need to be part of the care planning process? |  |  | |  |
| 2.0 | **Preparing for discharge** | | | | |
| 2.1 | Who will identify people who will be involved in the person's care and send a copy of the care plan to them within 24hours of their discharge?  The plan includes:   * recovery goals * how to cope with symptoms * what to do in a crisis * medicines and treatment, * work, training, learning or social activities. |  |  | |  |
| 2.2 | Links with life outside the unit… what support do they need to stay in touch with family and friends and restart activities? Can they leave the unit for short periods? These links are particularly important if they have had a long stay or have been out of area. |  |  | |  |
| 2.3 | Accommodation… has there been a discussion about the young person’s housing and whether it is suitable for them to return to |  |  | |  |
| 2.4 | Education... has a named worker been identified in their school or college and a meeting arranged with the young person to plan their return? |  |  | |  |
| 2.5 | Peer support… would the young person benefit from a group based self-management training programme or direct support delivered by trained people with experience of using mental health services |  |  | |  |
| 3.0 | **Care and Support After Discharge** |  |  | |  |
| 3.1 | The Young Persons care plan contains the following:   * Where they will be discharged to * The triggers that might cause a relapse and how to prevent it * Recovery goals and ways to manage their own condition * Ongoing treatment and support plan details * Who to contact for support? * Where to go in a crisis * Budgeting and benefits, including personal budgets if appropriate * Social networks * Educational and social activities * Medication details * Any physical health needs, including health promotion and information about contraception * Review date * What follow-up is required and preferred method of communication |  |  | |  |
|  | Are people involved in providing support to the young person at discharge listen in the discharge plan? E.g. GP, Social Workers, Crisis Teams |  |  | |  |
| 4.0 | **Crisis Plan** |  |  | |  |
| 4.1 | If the young person has had more than one admission staff will help them to write a crisis plan as part of their care planning. The plan  will:   * Focus on what will help them to stay well and avoid further admissions, and include: * Possible signs that their mental health is deteriorating and what to do * Who to contact? * Personal coping strategies * Any wishes they have about specific treatments or interventions |  |  | |  |
| 5.0 | **Information and support for parents and carers** |  |  | |  |
| 5.1 | A Named Practitioner is communicated to parents/ carers |  |  | |  |
| 5.2 | A carer’s assessment is offered to anyone, including siblings who will be supporting the young person |  |  | |  |
| 5.3 | Protected time is offered for parents/ carers to talk to practitioners |  |  | |  |
| 5.4 | Ongoing conversations occur about the young person’s progress during their inpatient stay and how ready they are for discharge |  |  | |  |
| 5.5 | Discharge Date is communicated well in advance of discharge |  |  | |  |
| 5.6 | Parent/ carers’ working patterns are taken into account around meetings to enable them to attend. |  |  | |  |

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| Action Plan | | |
| Next Steps needed | **Person responsible** | **To be completed by – Date** |
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This document has been developed from NICE: Quality Standard 12; Transition between inpatient mental health settings and community or care home settings and NICE and SCIE: Improving young people’s experiences in transition to and from inpatient mental health settings A quick guide for mental health practitioners supporting young people.