Key Worker Policy

MHAPPM/8048

Approved by:	General Manager – Mental Health & Addiction Services	**First Issued:**	November 2006	
Signature:	David Warrington	**Review Date:**	November 2023	
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Purpose

The purpose of this document is to outline the standards to be met by Te Whatu Ora – Te Matau a Māui (HBHNZ) staff, and to provide information and direction on:

- the role and responsibilities of a Key Worker to ensure there is a structured and systematic approach to providing care and treatment for people who use Mental Health & Addiction Services.

  Recovery coordination provides a framework for registered and non-registered staff to assist people in their Recovery.

  This document is to be used in conjunction with MHAPPM/8953 – Mental Health Service Policy which outlines the shared vision and expectations for the direction, values, principles, attitudes and ways of working to deliver a values-based service.

Principles

All HBHNZ documents are based on and link back to our values: **He Kauanuanu** (respect), **Ākina** (improvement), **Raranga Te Tira** (partnership) and **Tauwhiro** (care), and are detailed so all persons are provided with clear information on the way they are expected to practise and undertake tasks.

The following New Zealand Legislation and Standards are applicable to this document:

- The Treaty of Waitangi Act 1975
- Health Practitioners Competence Assurance Act 2003
- Health and Disability Commissioner (Code of Health & Disability Services Consumer Rights) Regulations (1996)
- NZS 8153:2002 Health Records
- New Zealand Health and Disability Services (General) Standards NZS 8134.0:2008

Scope

All staff of Te Whatu Ora health New Zealand, Te Matau a Māui Hawke's Bay Mental Health & Addiction Services.

Definitions

Refer to the Mental Health Service Definitions Glossary \\FS3\share\Public\All Users\MHS Policy review\DEFINITIONS FOR WORDS AND TERMS IN USE WITHIN THE MENTAL HEALTH SERVICE.docx

Roles and Responsibilities

Role	Responsibility
Key Worker	To comply with the standards as outlined in this document.

Te Whatu Ora – Te Matau a Māui (HBHNZ) Standards

Key Worker Responsibilities

1. Is the service provider who coordinates treatment, communications and activities for the person in order to assist them to achieve the goals specified in their 'Go To Plan'.
2. The name of the Key Worker must be recorded in the "Responsible HCP" field in the Primary Referral in Electronic Clinical Application (i.e. ECA: the electronic patient management system) and be kept continuously up to date.
3. Ensures the person can participate in the planning of their care and ensures their voice is heard.
4. Ensures the health record is maintained, regularly reviewed, and reaches the right people at the right time so decision-makers are fully informed.
5. Is the single main point of contact for all stakeholders throughout the episode of care.
6. Must stay closely involved with the person and maintain contact as frequently as required or dictated by the person's needs.
7. Ensures that family/whānau are included in all aspects of the person's care (unless the person declines their involvement).
8. Maintains responsibility for ensuring the person's 'Go To Plan' is progressed throughout any hospital inpatient admissions (general and/or psychiatric hospitals).
9. The Key Worker must make every effort to explain their role to the person, their family/whānau and friends and other practitioners, with whom the person is involved.
10. The Key Worker must assist the person to review their plan in collaboration with their family/whānau, unless the person declines their involvement.
11. Each person's 'Go To Plan' will:
    a) be reviewed regularly:-
        i. **daily** for people who are in-patients
        ii. at least **once every three months** for people in the community.
        iii. each review is to include the following stakeholders (where possible): -
            i. the person
            ii. the person's nominated significant other or family / whānau
            iii. the Key Worker
            iv. the community support worker (if allocated)
            v. the Needs Assessment & Service Coordination worker (if allocated)
            vi. the Psychiatrist
            vii. The General Practitioner
    b) Have person-led goals which are realistic, achievable, outcome focused and will include relapse prevention strategies, with clearly described review timeframes.
    c) Have individual responsibilities and ongoing achievements documented.
    d) Record if the person does not wish to participate in their plan. If they do not, then a plan must be developed without their participation, but including whānau/family unless the person declines their involvement.

12. The Key Worker must ensure all mandated outcome measures are completed in ECA according to any collection rules (e.g. the "Health of the Nation Outcome Scale" HoNOS HoNOSCA or HoNOS65+ & "Alcohol & Drug Outcome Measure" (ADOM)) and be discussed with the person and/or family/whānau (unless inappropriate).
13. The Key Worker must ensure that a copy of the persons 'Go To Plan' is given to the person and family/whānau unless the person declines family/whānau involvement.
14. The Key Worker must monitor the 'Go To Plan' and review it in response to any significant changes and/or missed appointments.
15. The Key Worker must ensure that appropriate contact is maintained with the person. Appropriate contact is dependent upon the individual needs of the person and should be documented in the 'Go To Plan'.
16. The Key Worker must maintain Health Records that meet the New Zealand Standard Health Records NZS 8153:2002 and comply with the requirements of the Health Record Policy TMMHB/OPM/074
17. The Key Worker must support the person by promoting 'Advance Care Planning' and by assisting the person to access advocacy service(s).
18. If a Doctor is the only Health Care Practitioner involved with the person then they are, by default, the Key Worker and shall complete all Key Worker tasks as per this document.

Referral

19. For people aged 18 to 64, refer to MHAPPM/8954 - Community Mental Health Care Pathway Guideline.

Recovery Planning

20. During the initial contact between the Key worker and the person, the Key worker is responsible for:
    a) Coordinating the provision of a holistic comprehensive assessment.
    b) Ensuring a 'Go To Plan' is completed according to the requirements of MHAPPM/8046 - Health Record Policy for Mental Health & Addiction Group.
    c) The Key Worker role cannot be relinquished or transferred until a documented agreement has been reached with another Health Practitioner to take on the role (including the date upon which the transfer is to occur) or the person has been discharged from services.

Risk Assessment and Management

21. The best predictor for future behaviour is past behaviour. Key workers need to be alert to factors that indicate the person is at risk of harm to self or others, including, but not limited to:
    a) recently discharged from mental health inpatient services.
    b) recent crisis or change in the person's life / work / relationship / status / family perceived or actual loss.
    c) a level of hopelessness.
    d) co-existing disorders, eg. substance misuse / physical illness.
    e) past history of harm to self or others.
    f) increased emotional liability, irritability.
    g) mood becomes depressed or more cheerful after a period of depression.
    h) a plan or expressed intent for harm.
    i) command hallucinations.
    j) abuse issues.

Review

22. The Key Worker needs to continuously monitor and review the services provided to the person, particularly when there are changes to the 'Go To Plan' or the person's needs change.
23. Documentation must to be maintained on all aspects of recovery planning and review.

Missed / Cancelled Appointments

24. Will be managed as per CPG/035 - Did Not Attend (DNA) – Guidance Policy.
25. When the person fails to attend a scheduled appointment, (i.e. DNA) the level of individual risk and the current situation must be assessed by the Key Worker or Duty person and documented in the persons health record.
26. Within 48 hours there will be contact with the person who 'Did Not Arrive' to reschedule the appointment.
27. Contact is defined as a phone conversation, phone message left and responded to by the person, text sent and response received, email (or any other digital messaging service) sent and email received back.
28. If they cannot be contacted, their next of kin, identified support person and the referrer should be contacted. This must be documented in the Health Record.
29. This must be discussed with the immediate care team without delay and a plan formulated to address any identified care requirements. This plan must be documented in the Health record. Refer to CPG/035 - Did Not Attend (DNA) – Guidance Policy.

Discharge

30. Discharge planning should begin from the day the person was referred to the Mental Health and Addiction Services.
31. If the person has declined their family/whānau being involved in the discharge process then this must be documented in the health records at each step.
32. A decision to plan to close an episode of care should be made , in conjuctation with the person and (where possible) their family/whānau.
33. All discharges from the service will be reviewed at an MDT meeting prior to discharge from the service.
34. A face-to-face discharge planning meeting between the person and their Keyworker should be held within two weeks prior to the estimated date of discharge from the service. The person's 'Go To Plan' must be updated at this meeting. The person's family/whānau will be part of this meeting unless the person declines to have them present. For family/whānau who can not be physically present, telemedicine will be used to ensure they can be part of the meeting.
35. Any barriers to discharge to GP care to be considered (i.e. complex case, will they attend, financial issues, ongoing scripts), and if identified, the Keyworker, with consent, should also attend the whaioras appointment with their GP immediately prior to closing to Mental Health & Addiction Service as part of the transition plan
36. An explanation and agreement of how to access the Mental Health & Addiction Service will be shared (where possible) with all involved.
37. A Letter or note to the GP / referrer (via Clinical Portal) to advise of the person's discharge plan.
38. The person's 'Go To Plan' must be updated within the two weeks prioir to the closure of the Primary Referral.

a. The 'Go To Plan' becomes the person's 'transition plan' – as they transition between the care of the Mental health and Addiction Services and their Primary Care provider / General Practitioner.

b. The person must be given a copy of their final 'Go To Plan' on (or before) the day of discharge.

c. The person's family whānau must be given a copy of the final 'Go To Plan' on (or before) the day of discharge, unless the person declines them having a copy . If the family/whānau were jolt given a copy of the 'Go To Plan' then the key worker needs to specify in the health record why the family/whānau were not given a copy of the go-to plan.

Risks and Hazards to Staff

Risk / Hazard	Control
Lone Working	OPM/097 - Working Safely in the Community Policy

Measurable Outcomes

Documentation is completed within agreed timeframes.

Every person will have a 'Go To Plan' plan that is holistic, accurate, complete and dated.

Each person (and their family/whānau) will know who the Key Worker is and know how to contact them and know where and how to access support.

Related Documents

MHAPPM/8953 – Mental Health Service Policy

MHAPPM/8954 – Community Mental Health Care Pathway Guideline

OPM/074 – Health Record Policy

OPM/097 - Working Safely in the Community Policy

CPG/035 – Did Not Attend (DNA) – Guidance Policy

References

Mental Health (Compulsory Assessment and Treatment) Act 1992

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

NZS 8134 : 2021 Ngā paerewa Health and Disability Services Standard

Key Words

Key worker
Mental
Recovery
Care
Plan
Well-being
Coordination
Planning
Wellness

For further information please contact the Quality Systems Manager – Mental Health and Addictions Service