Making you part of
the Triangle of Care
Information for carers
Introduction

You may have been given this leaflet because someone you care for is receiving treatment or support from Lincolnshire Partnership NHS Foundation Trust (LPFT). As a Trust specialising in mental health, we understand some of the difficulties faced by those who are personally involved with individuals who have mental health concerns.

We have developed this leaflet to help support you as a carer in this journey.

This leaflet has been designed by the Triangle of Care steering group and Lincoln’s Discovery House Carers’ Group.

It is estimated that one in four people will suffer from a mental health problem each year and so it is likely, that if you do not suffer from mental ill health yourself, you will know someone who does. Many people who know someone with mental health problems struggle to know what to do for the best. What support they should give, when they should give it and when they should seek help from someone else.

LPFT expect our staff to treat you with courtesy, dignity and respect at all times. We will treat you as an individual, listen to your ideas and concerns, and support you as much as we can regarding your needs as a carer. Support will be offered by nursing staff and in carers’ meetings. If we are unable to help then we will endeavour to help you to make contact with an appropriate agency. In return we ask that you afford our staff, service users and other visitors with the same courtesy and respect.
What is a carer?

‘A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support’. (Carers Trust, 2016).

We have found that many people do not know that they are considered a carer. Therefore, many carers are not aware of their rights to support and information. The Care Act 2015 has given local authorities a responsibility to assess the level of support a carer may need.

What is a carers assessment?

The local authority has a legal responsibility to assess what support a carer might need. A carer is entitled to a carers assessment regardless of their own financial situation, or the level of support that they give to the cared for.

The assessment is for the benefit of the carer and can be completed with or without the presence of the service user. A carer can self-refer to the local authority to request a carers’ assessment or ask a mental health professional to make the referral for them.

To make a referral you will need full contact details of the person who is cared for as well as the carer themselves. A carers’ assessment can be requested by contacting Lincolnshire County Council.

Full contact details are,

The Carers Team,
Customer Service Centre,
Witham Park House,
Waterside South,
Lincoln,
LN5 7JN

Tel: 01522 782224
(From 8am-6pm, Monday to Friday),

Tel: 01522 782333
(From 6pm-8am emergency out of hours),

Email: carersservice@lincolnshire.gov.uk
Meet the team

Chaplain
The chaplaincy and spiritual care team help people to build up their own inner resources. They help people use their spirituality more confidently, whatever their tradition, religious background or beliefs, at any part of their journey.

The team are also involved in training and projects to promote knowledge and understanding of mental health issues amongst the wider faith communities. They are supported in their work in the Trust by chaplaincy volunteers.

If a carer, or a service user, wishes to speak to a chaplain please ask the nursing staff to contact them on your behalf.

Carers lead
Every LPFT inpatient ward has a carers’ lead nurse with specialist knowledge of support, information and resources available in the Lincolnshire area. However, any member of the team should be able to answer their queries and concerns.

Consultant psychiatrist/responsible clinician
Consultants are medically trained doctors who are specially trained in psychiatry. Our consultants are able to discuss, review and prescribe medications; they may also recommend holistic therapies such as dialectical behavioural therapy. Please be aware that a service user may have a different consultant in an outpatient setting to an inpatient setting.
Psychologists
Psychologists work in many different areas of society and are concerned with practical problems.

Psychology is the study of how people think and behave – a combination of science and practice. Using direct observation, interviews and techniques, such as psychometric testing, they make an assessment of a patient’s problem. Treatment usually takes place over a series of sessions and requires the cooperation of the patient.

Named nurse
In an inpatient setting, service users will be allocated a named nurse who will offer one-to-one support. This contact is important to build rapport and trust with an individual staff member. The nursing team are able to discuss concerns and to develop a care plan of how to address any areas which require support or interventions. Nurses will also administer medications and injections prescribed. Named nurses are an important contact for carers as they are central to communication between the ward team, carer and patient.

Nursing Assistants
Nursing Assistants support the role of qualified practitioners to ensure that service users are being nursed in adherence to their continuing care plan.

Pharmacy
The pharmacy team are able to provide information and advice on medications used on the ward. Their role is to help carers and patients understand medications, their intended outcome, the best option available and alternatives, side effects and how to take medication.

The pharmacy team have a wealth of information on the Trust’s website www.lpft.nhs.uk/services/pharmacy. This has information about conditions as well as the typical medication used to manage symptoms. You can ask the nursing staff to make an appointment with a pharmacist if you wish to speak to someone face-to-face.
Occupational Therapist
The role of occupational therapy is to promote service user’s independence. Occupational therapists may liaise with carers to get an idea of what interests and level of engagement the service user may have. They complete home visits and assessments, such as cooking, vocational and community skills and offer interventions surrounding this. Within the therapy team is a chartered physiotherapist who is able to assess movement and function when someone has an injury, illness or disability and prescribe interventions such as exercise plans and adoptions/equipment with the occupational therapist.

Ward/Service Manager
The role of the manager is to ensure a high quality, safe and effective level of care and oversee the day to day running of the service. The manager is available to talk to if you have any particular questions or concerns that the nursing team cannot answer or resolve for you.

Community psychiatric Nurse (CPN)
A CPN is a qualified nurse who is based in the community rather than the inpatient setting. The CPN will act as a service user’s key worker and acts to refer the service user to other mental health professionals. The CPN may visit service users at home, at a GP surgery or at the community mental health’s team base.

Care Coordinator
The care coordinator conducts a holistic approach to care and ensures that the multidisciplinary team conduct regular reviews (usually six monthly unless otherwise agreed) and provide continuing evaluation and assessment of the service users continuing care plan. The care coordinator will coordinate the care when the service user is in the community and will continue to be involved if the service user requires going into hospital for any period.
What is a CPA review?
A CPA review is completed on a regular basis regardless of whether the service user is an inpatient or outpatient. This involves relevant professionals, a handover from the therapy team and will often require a carers’ presence so that they can relay information to the team. Also the team speak with you about approaches taken and discuss proposed leave from the ward. A CPA meeting will always be held before a service user’s discharge from mental health services in order to agree an appropriate discharge plan of care. If you cannot attend a meeting please speak to a member of the nursing team or the responsible clinician to express your views.

Crisis and contingency planning
For service users that go on leave or are discharged from inpatient services a crisis and contingency plan will be collaboratively developed with service users, carers and nursing staff. This is to assist in agreeing with how to manage difficult situations in the community. Later in this booklet you will find information on techniques to support you in managing such circumstances.

Care Programme Approach (CPA)
The CPA identifies:
• An assessment of patient needs.
• A named professional responsible for coordinating care.
• A written care plan or statement of care.
• A regular review of care.
The Trust’s policy states that staff should be “sensitive to the service user’s wishes and confidentiality requirements; engage with family members and carers as care partners”. To ensure the rights of confidentiality for the service user, staff will always seek consent from them to share information with their family and friends. Service users are entitled to decline consent for information to be shared with their family and friends or they may set specific limitations to information that can be shared. For consent to be given, the service user must demonstrate that they:

- Have the mental capacity to make the decision whether to consent or refuse.
- Have been provided with all of the relevant, and sufficient, information.
- Not be under duress or excessive pressure.

However, carers, family and friends also have rights to confidentiality which means that they must be offered the opportunity to pass on their thoughts and/or information to the nursing and medical team involved in the care of their loved one. Carers can ensure that their voice is heard by speaking to the nursing staff or the responsible clinician. Carers, family and friends can also give or decline consent for information that they share to be passed onto the service user. If you do give information you wish to be kept private from the service user, please ensure that you inform the staff member of your wishes at the time of sharing the information.

It is important that Trust services have your up-to-date contact information, so that we can continue to include you in your relatives care planning. We would ask that you advise us of any changes to your contact details, at the earliest opportunity.

In order for mental health staff to help address your needs please let them know your role. Are you a friend, next of kin or first contact, and do you have any special requirements, such as are you a young carer?
Advance statement/directive

An advanced statement is a broad term used to describe a service users wishes about their continuing care and treatment, involvement of an advocate, family member or next of kin, and their personal beliefs and values.

An advanced directive is a specific term used in crises and contingency planning to describe preferred treatment choices and strategies when dealing with a specific incident.

An advanced statement/directive should be discussed and decided after an inpatient admission, when the service user is demonstrating the ability to reflect and has capacity. The patient must demonstrate capacity at the time of making the statement or decision and this information must be documented appropriately. An advance statement/directive is not legally binding but healthcare professionals should take them into account when the service user’s capacity is lost. It is a good idea to discuss these with your relative when they are mentally well.

Safeguarding

Mental health professionals have a duty of care to report any information that may indicate that a person is at risk of psychological, physical, emotional, financial abuse and neglect.

Please be aware that any information you, or the service user, share that raises concerns about yourself or someone else may have to be reported to the safeguarding team. Staff will ensure that they gather as much information as they can, to take to the service manager (if appropriate) and multidisciplinary team. The team will then discuss whether a safeguarding referral is needed at that time. Staff will ensure, where possible, that any concerns are discussed with you directly and further information will be shared if a safeguarding referral is deemed necessary.
Deprivation of Liberty (DOLS)

DOLS can only be applied to informal service users who are deprived of their liberty. This means that restrictions have been placed upon them, which are against their human rights, in order to minimise risk. DOLS can only be applied to service users who do not have capacity.

Capacity

Capacity is the ability to make decisions for yourself about a particular matter. Having capacity means being able to understand and retain information about the decision, understanding the consequences of any choice you make, taking that information into account and being able to communicate your wishes.

Advocacy

TotalVoice Lincolnshire is an independent service that can provide support and information to carers of service users open to LPFT services. TotalVoice is also able to signpost carers to services with regards to financial issues, counselling and mediation. The carer or the professional can make a referral by telephone or in writing. TotalVoice contact telephone number is 01529 400479 and the email address is TVL@voiceability.org www.totalvoicelincolnshire.org.
The use of restrictive interventions (RI)

Within inpatient services it may be necessary to utilise restrictive interventions to prevent harm to self or others. Nursing staff are trained in various de-escalation techniques which are always used before any restrictive intervention. The physical holding of patients is always used as a last resort when all other interventions have been attempted or the situation is an emergency or to administer medication. If you are witness to any intervention please remove yourself for your own safety. If you are witness to any incident which causes you concern, please seek out a member of staff, once they are free, to discuss your concerns.

Nursing staff will only physically intervene to prevent a service user from harming themselves or other people.

Mental Health Act

If a service user is informal this means that they are in agreement to stay as an inpatient on the unit, to be assessed and receive treatment if required. Formal service users are detained under the Mental Health Act 1983. The most common sections used are as follows:

Section 5(2) – Doctors’ holding power for up to 72 hours to allow further assessment.

Section 5(4) – Nurses’ holding power for up to six hours to allow further assessment.

Section 2 – Assessment for up to 28 days.

Section 3 – Treatment for up to six months.

Section 136 – Used in public places, by the police, to take a person to a place of safety for assessment for up to 72 hours.

Section 135 – Warrant to remove a person from a private dwelling for assessment for up to 72 hours.

Section 17 – Leave of agreed absence that can be taken from the unit.

Section 37/41 – Hospital order imposed by court with no specified time but will have certain restrictions if the 41 is in place.
Locked and unlocked wards

Wards may be locked in order to keep informal and formal service users safe. If all service users are detained on a ward, the ward can be locked on a permanent basis. Wards which have a mixture of both formal and informal service users may lock their doors. However, informal service users have a right to leave the premises on request, unless they present as a risk to themselves or others. Informal service users insisting on leaving the premises may be assessed under the Mental Health Act.

Smoking

Smoking is not permitted anywhere on Trust sites in line with our smoke free policy.

If you choose to smoke you must leave our premises.

Due to the restrictions on smoking we therefore ask that you do not bring in any lighters, matches or smoking related items onto the premises.

E-cigarettes can be used in designated outside areas.

Nicotine replacement therapy is available for service users and stop smoking advice is given to service users who request it.
Compliments, suggestions and complaints

We hope that your engagements with LPFT services remain positive and ask that you take the time and opportunity to inform us of any concerns or compliments that occur to you. Our lessons learnt approach ensures that we listen to our carers and use their comments to shape future care in the best possible way.

Please inform a representative from the appropriate service of any complaints that you may have in order to allow us to immediately address your concerns. If you are not happy with the results of this meeting then please put your concerns in writing to the service manager (staff can provide you with the appropriate contact details).

If you feel you do not get a satisfactory answer from the service manager then please contact the Patient Advice and Liaison Service (PALS) for additional support in getting your concerns addressed. The contact details of PALS are:

Patient Advice and Liaison Service telephone number is 01529 222265 and the email address is PALS@lpft.nhs.uk.

You can also refer to our Experiences Count leaflet for more information.
Jargon Buster

We often use words in our everyday language that you maybe don’t understand so we thought a jargon buster might help so you know what it means if you hear these terms used by nurses and doctors!!

PRN – as and when required medication

BD – twice a day – usually talking about a frequency of medication

TDS – three times a day – usually regarding medication frequency

QDS – four times a day – usually regarding medication frequency

Mane – in the morning – usually regarding medication frequency

Nocte – at night – usually regarding medication frequency

IM – intra muscular (injection) – an injection given to the patient into a muscle

Depot – antipsychotic medication given in the form of an injection

MDT – multi disciplinary team made up of doctors, nurses and other professionals

MDM – multi disciplinary meeting where all the professionals involved meet up

RC – Responsible clinician – usually the consultant psychiatrist involved with a patients care

CTO – Community treatment order – restrictions apply when out of hospital. This can be around compliance with medication

RI – restrictive intervention – a taught technique whereby staff physically hold a person to prevent them from hurting themselves or others

AMHP – Approved mental health professional – usually a social worker or nurse who assesses mental state under the mental health act

EDT – Emergency duty team – an out of hours service of AMHPs
Planning for an emergency/crisis

Crises can happen at the most inconvenient times – late at night, over a weekend for example. At such times it is not easy to respond in the best or most appropriate way.

It is helpful therefore, to try to think about some of the worst case scenarios in advance, how you might respond, who you might call on and where to keep this information safe and handy. In this way, if things do get difficult, you have some sort of plan set up to help you through.

You will need to know the numbers of out-of-hours services that are available in your area and have them by the phone or in the phone book. Similarly, you will need the numbers for relatives and friends who can be called on at short notice, either to give you support in your home or, if you have to go away, support for those left behind. This is especially vital if it is you who has an accident or crisis rather than a relative or friend with a mental illness.

Contact numbers for all services involved in your relatives’ care, and others who support you, should be kept with you at all times. With agreement, they should also be written in to your relatives’ notes so that they are readily accessible to any persons who might need them.

These plans should be drawn up and agreed by you and the relative/friend you provide care for when that person is calm and in a stable condition so that everyone is clear about what will happen. This is not always easy as when someone is well you are trying to be positive and not think about the bad times. However, if you can have some contingency plan it may be helpful in actually avoiding a really serious crisis.
This might also be the time to think about drawing up a confidentiality agreement or an advance statement or directive. If you are the person responsible for your relative/friend being sectioned or admitted to hospital voluntarily, you will possibly be the last person they wish to be told about what is happening to them. ‘Patient confidentiality’ can sometimes be a source of irritation when your relative is unwell and staff won’t give you information.

If you are likely to be someone helping with your relative or friend’s care when they leave hospital you will obviously wish to be informed about what is happening, how things will be managed in the future and how you will be included in the process. You may need to find some way of encouraging your relative or friend to include you in the discharge planning, helping them realise that you will be a useful ally in their care.

In order for the agreement to carry weight with the professionals you need to ensure that you have discussed it thoroughly with your relative or friend have it documented in the service users’ notes by a mental health professional. It will probably be a more acceptable arrangement for your relative or friend if they feel that some pieces of information are retained as being confidential e.g. discussions in therapy groups or individual counselling sessions or seeing their records. In this way they can still maintain control while at the same time allowing you access to information it would be useful for you to know.. This is beneficial for all parties and ensures that professionals do not breach any of their guidelines.
Talking to someone with delusions, unusual beliefs or hallucinations

A delusion is a false belief that cannot be swayed by concrete evidence. A hallucination is not a delusion or a false belief. Hallucinations are sensory perceptions involving any of the five senses. One of the most common ones is hearing voices. Hallucinations may also be evident in a number of illnesses as well as schizophrenia, probably the most common being high temperatures from infections (especially in the young and elderly) or withdrawing from alcohol or drugs. The term psychosis is used when the person loses touch with reality and may be suffering from hallucinations and/or delusional beliefs.

- Don’t dismiss the delusion – recognise that these ideas and fears are very real to the person but also do not agree with them e.g. “I don’t believe ….. is out to get you but I can see that you are very upset about it”.
- Don’t act horrified by bizarre words or unfinished sentences. Say “I don’t really understand what that means” or remind them of the conversation you were having and distract them back.
- Don’t let others laugh about the delusion, hallucination or strange talk.
- Don’t ask the person to try to force the voices to stop.
- Do act calm.
- Do try to distract by involving them in something interesting. Go to look for something with them, chatting about everyday things and involving them with close friends/family.
- Do give the person time and space if they do not want to talk. Say “I can see you don’t want to talk now, but I’ll be here for you if you want to talk later”. Allow time for them to recover their pride, their thoughts and their composure etc.
- Do find someone to talk to, to let off steam yourself – another carer, a support group, a professional – anyone you feel comfortable with.
Dealing with difficult behaviour

• Don’t act impulsively – talk things through
• Don’t invade space
• Stay at arm’s length
• Avoid putting yourself in a corner
• Always knock
• Get to know the signs – pacing, rocking, stuttering, fist clenching
• Keep neutral body posture
• Keep hands in sight – show the palms of your hands
• Don’t clench your fists, put hands on hips, stare or point
• Make eye contact – but don’t stare. Smile.
• Be self-aware – be aware if you are in a bad mood as this will be picked up!!
• Be calm – walk slowly, don’t show agitation or irritability
• Count to 10 – it does work
• Use humour – but avoid negative humour or sarcasm
• Empathise – “I think I know how you feel”
• Sympathise – “I agree with you”
• Ventilation – let someone get it off their chest. Don’t interrupt or argue.
• Get them talking – open ended questions “How did that feel?”
• Avoid physical contact – don’t grip an arm, shake them awake
• Set ground rules – let the person know the limits and consequences.
• Know who to call in an emergency
• Don’t get involved in a pointless argument
• If your friend/relatives flares up and storms off – leave them to cool down before talking to them – don’t try at that time
• Take a break – it can be exhausting, worrying and a 100 other emotions. Give time for you.
Dealing with self-harm

People injure themselves for many reasons. It can replace emotional distress with physical pain. Many people say that when they cut themselves they experience a release of tension and so they often feel calmer. In a strange way self-injury may help people feel that they can achieve some degree of control in their lives.

Self-injury is very often not a suicide attempt; however people who do self-harm are at a greater risk of suicide than the general population due to their high risk behaviour. They should not just be seen as “attention seekers” or “manipulative”.

Relatives, friends or professionals trying to help the person can find it very stressful, especially when the person does not want to talk about or explain their behaviour. It is easy to feel ‘shut out’ and just left to pick up the pieces when in crisis. If someone we care about is deliberately damaging him or herself and not willing to let us help we feel isolated and powerless.

The person usually has very low self-esteem and poor self-worth, or they may be in a state of psychosis, and they think that others will see them in the same light and be critical of them. There are therapies that can be used that have been shown to be effective in breaking the negative cycle.

Useful pointers:-

• Respond to an incident of self-harm in the same way that you would for an accident. Give first aid as you would for any physical injury

• Do not assume that the person either enjoys or does not feel pain. A response which implies criticism or some form of punishment simply reinforces the persons feelings of guilt and self-blame
• Acknowledge the persons distress – say something like “I can see you are very upset. How can I help you?” This is reassuring to the individual and gets a rapport going
• Aim to be positive and comforting rather than negative or emotional. This can be hard to do but do not show annoyance or criticism.
• Don’t promise everything will be okay. Acknowledge there is a problem but reinforce there is help available
• Try to have a contingency plan in place in times of crisis so you know what to do. This can help reassure you.
• If you think someone is suicidal as there is a change in usual behaviours let someone know. You can contact the person’s care co-ordinator or contact an emergency crises team. The contact details of any crises contact should be documented in a crises and contingency plan.

The information provided to assist you in managing difficult situations is a guide only and we would encourage you to seek help at the earliest opportunity if you feel in danger or your loved one is at imminent risk.

With kind thanks to Sam Elson, Deputy Lead for Triangle of Care for the information gathering for this leaflet.

Donna Bradford is the Trust Project Lead for the Triangle of Care for LPFT and can be contacted on 07802569995
Ward specific information

Here is some information about the ward your relative or loved one has been admitted to:

Your relative has been admitted to
........................................................................................................ (ward/unit).

This unit is a ........................................................................................................
(description of what type of ward it is).

Contact telephone number for the ward/unit is
....................................................................................................................

The patient telephone number is
....................................................................................................................

Your relative’s named nurse is
....................................................................................................................

The Responsible Clinician for your relative is
Dr....................................................................................................................

Visiting times for the ward/unit are..................................................................
....................................................................................................................

As this ward/unit admits patients who
require...........................................the expected admission times are......................

Please speak to a member of staff/named nurse about whether your relative can be taken out. The staff can explain any restrictions that may be placed on your relative. Please expect your relative to be assessed and treated for their illness. The Carer Lead for the ward/unit is..............................................................and you can contact them if you require any information or support.
If you would like this leaflet in another language or format, such as Braille, large print or audio please contact:

Leaflet designed and printing sourced by the LPFT Communications Team

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Every effort has been made to ensure that the information in this leaflet was correct at the time of print. However, changes in law may mean that in time some details in this leaflet may be out of date.

Anyone using our services will be treated with dignity at all times and their faith and cultural needs will be accommodated where practically possible.

The Trust is fully compliant with the Data Protection Act and the NHS Code of Conduct.

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Contact us

www.lpft.nhs.uk
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Twitter.com/LPFTNHS